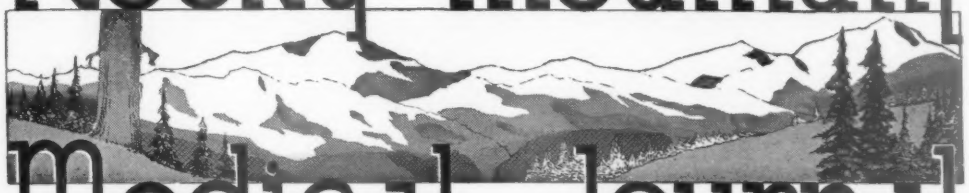
Rocky Mountain Medical Journal



Colorado and Montana Annual Session Highlights

October 1954

Vol. 51—No. 10
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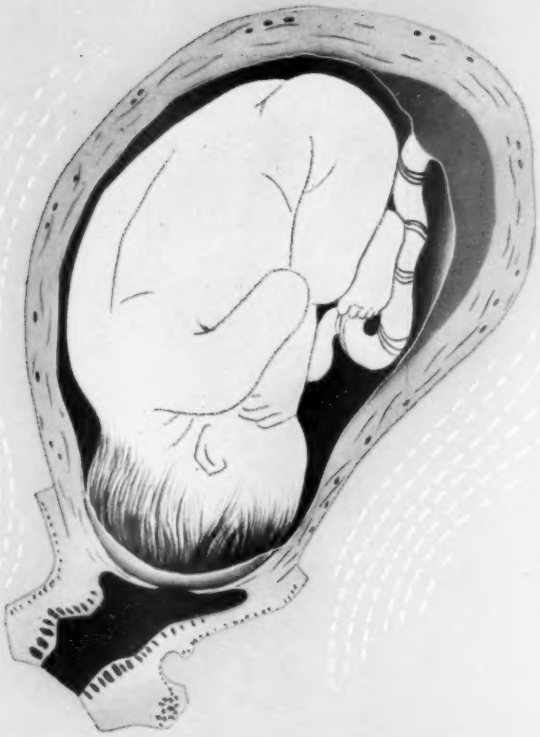
THE NOSE IN YOUR FACE — UROLOGIC PROBLEMS IN GENERAL PRACTICE



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*Kaufman, R. H.; Mendelowitz, S. M., & Ratzan, W. J.: *Am. J. Obst. & Gynec.* 65:269, 1953.

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OCTOBER, 1954

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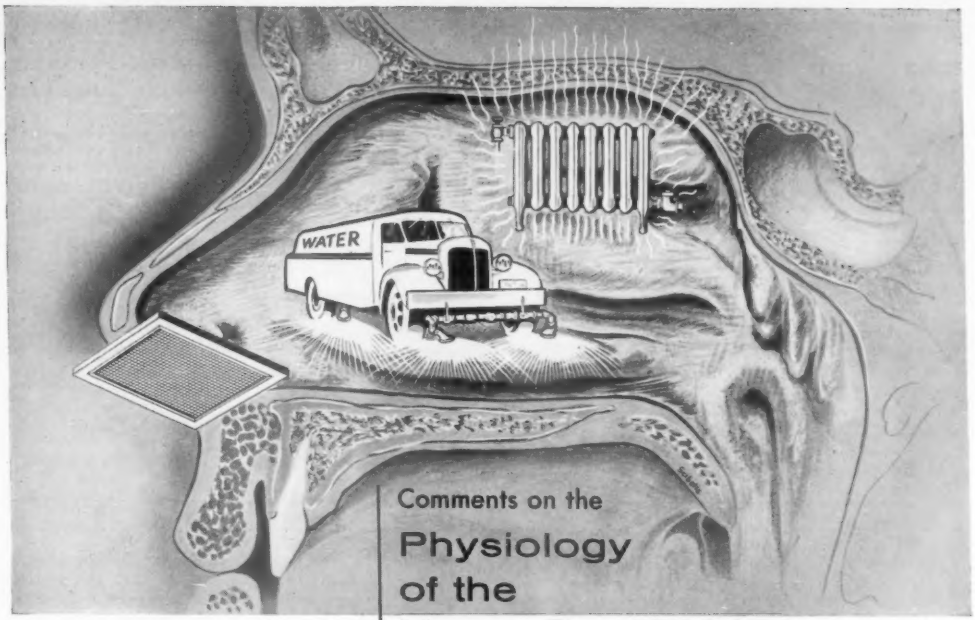
Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a nonprofit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, the Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

Advertising: National representatives: The State Journal Advertising Bureau, 535 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 15th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

Subscription: $3.50 per year in advance, postpaid in the United States and its possessions; single copy 35c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

Second Class Matter: Entered as second class matter Jan. 22, 1906, at the Post Office at Denver, Colo., under the Act of Congress of March 3, 1879. Accepted for mailing at special rates of postage provided for in Section 1103, Act of Oct. 3, 1917; authorized July 17, 1918.



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NEXT ANNUAL SESSION: SEPTEMBER 20-23, 1955; SHIRLEY-SAVOY HOTEL, DENVER

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Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1955 Annual Session.

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General Counsel: Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

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NEXT ANNUAL SESSION: ALBUQUERQUE, MAY 4, 5, 6, 1955
(Joint Meeting with Rocky Mountain Medical Conference)

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Counterbalanced tube stand, providing adjustable focal-film distances up to 40 in.	YES	NO	NO	NO
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12-step line-voltage compensator	YES	NO	NO	NO
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References: 1. Hollander, F.: Arch. Int. Med. *93*:107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Interim Session A.M.A., St. Louis, December, 1953

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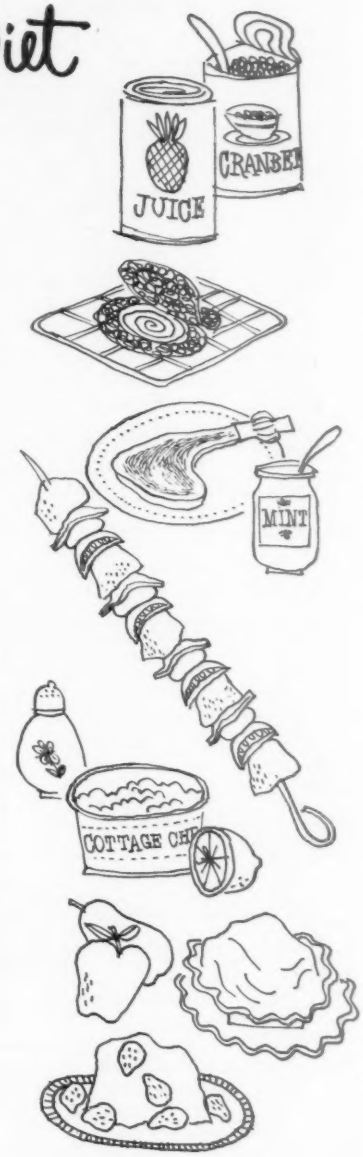

Palatability is the key to planning this diet. And these flavor tips will help you keep in the "taste appeal" your patient must have and still keep out the rich foods he cannot have.

These are for flavor—

Cranberry and tomato sauce pinch-hit for gravy. Fruit juices are to baste with as well as to drink. And herbs and spices lend a fine aroma to meats and vegetables.

Here's where they go—

Meat loaf can sport a gay cap of whole-cranberry sauce, while hamburgers make a surprise party when a slice of pickle or onion is sealed between two thin patties. Your patient can baste chicken with lemon or orange juice—glaze lamb chops with mint jelly. Lean meats, broiled or baked, are made savory with herbs. And barbecued kabobs add something different.

Most vegetables can be dressed simply with lemon juice or an herb vinegar. And tomato halves come out from under the broiler bubbly with brown sugar and sweet basil on top.

On green salads, cottage cheese thinned with lemon juice, sparked with paprika, makes the dressing. And on fruits, try lemon juice, honey and chopped mint.

For dessert, angel cake or meringue shells go nicely under fruits—skim milk powder makes the "whipped cream." Snow pudding is a simple dessert—fresh fruit, even more so. And for a change, your patient may like his fruit baked in grape or cranberry juice.

The diet, of course, will be balanced nutritionally at a suitable calorie level. And these "diet do's" will help keep your patient happy within the limits you set for his diet.

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Rocky Mountain Medical Journal

OCTOBER, 1954

Colorado - Montana - New Mexico
Utah - Wyoming

CRITICS of the medical profession who have been wildly claiming an alleged shortage of doctors and a scarcity of teaching facilities will find no comfort in the latest annual report on medical education in the United States, issued by the American Medical Association. The report tells a heartening story of continued progress and expansion to produce an ever-increasing supply of well-trained physicians dedicated to the welfare of their patients. Among the highlights:

More Doctors For America

. . . The number of physicians is now at a record ratio of one for every 730 persons, a proportion exceeded only by Israel, which has an abnormal number of refugee physicians.

. . . The nation's medical schools have made new records in total enrollment, graduating classes, and the largest freshman class.

. . . Ten new four-year medical schools are scheduled to begin operation within the next five to six years, and three more are under consideration.

The expansion bears out the opinion of medical education experts that the big problem in the near future may be a shortage of well-qualified applicants rather than a shortage of teaching facilities.

Young people should be told that only 21 per cent of the freshmen entering medical school last fall had "A" averages in their pre-medical studies, 69 per cent had "B" averages and 10 per cent had "C" averages. In other words, they don't have to be Phi Beta Kappas to get into medical school. Most young people who have the character and a sincere desire to serve their fellowmen as physicians have an excellent chance of entering medical school.

SOME interesting research was demonstrated before the American Association of Plastic Surgeons during its recent annual meeting at the Medical Branch of the University of Texas in Galveston. Dr. Charles M. Pomerat, Professor of Cytology in the Department of Anatomy, talked upon the subject, "The Analysis of Thermal Stress With Tissue Culture Methods." Incidental to the lecture, the author showed a film of living tissue exposed to various liquid substances and photographed under a magnification of 50,000. The cells were demonstrated clearly, and such processes as laking, crenation, and mobility were seen in dimensions rarely visualized except by colleagues who have access to our more elaborate optical instruments. Indeed, the minute frontiersmen of life itself were clearly before our eyes.

The Minute Frontiers of Life

When viewing physiologic processes of individual cells, one realizes what wondrous powers these cells possess, the heroic battles they wage for survival, and the magnificent wars they wage to perpetrate life and health of the individual. Fortunately for

human beings, the leukocytes are unbelievably aggressive on our behalf and their voracious appetite for invading organisms which would destroy us is insatiable. Under the great microscope, mobile cells may be followed and practically cheered on, as we might the contestants in any battle for superiority or survival of the fittest. One wild leukocyte traveled all over the field thrusting out its pseudopods into every available intercellular space as though looking for its foe—or perhaps its mate. Being springtime, perhaps the latter assumption is correct; at least it's more biologic and more pleasant to contemplate! Said the speaker, "He's having a hell of a time!"

By this technic, the effect of various substances upon live cells may be visualized and appraised. For example, we think normal saline solution is innocuous and kind to tissues because it is isotonic with them. However, under tremendous magnification we note rupture of cellular walls, as though they are made to explode; other cells will change color and shape and even die when exposed to substances supposedly benign. It is easy to demonstrate that normal saline solution needs the addition of such substances as calcium, colloids, and even plasma substitutes to minimize its damage to delicate human tissues.

Thus, minute exploration of thermal and chemical stress within, and upon, the cellular elements of human tissue heightens our respect for them. Every physician should be mindful of their vulnerability whether it be in prescribing drugs or incidental to the practice of surgery. Obviously our bodies are composed of what we ingest and breathe, as our less tangible minds are composed of what we are and what we think. Both are delicate and vulnerable to every manner of adverse extraneous influence.

It therefore behooves medical men to think of possible evils as well as the good potentialities of medicines. Every substance administered orally or parenterally will be widely distributed and ultimately eliminated. In the interval, it may do good, harm, or no good and no harm. We know that a lot of expensive medicine ends up down the drain, especially when antibiotic drugs are used as "shots in the dark" without available biologic assay. Furthermore, the surgeon should handle his tissues with infinite gentleness, for crushing and stretching of tissues opposes and destroys the minute frontiersmen of which we speak. He must not abuse the flesh upon which he works, adding to the trauma by use of chemicals which destroy cellular elements of tissue as well as bacteria. Suture material unnecessarily coarse or strong, and instruments which crush or tear, lead to ischemia and even necrosis.

Let us always remember the valiant battles which are constantly being fought at these small frontiers on behalf of the lives of our patients and ourselves. They miraculously determine our abiilty to survive, and it is our duty to respect them to the greatest possible extent—helping when we can, but never hindering. Here, also. our research workers are looking for the cause of cancer and other foes of human life.

American Medical Education Foundation

LET us not forget that every physician should be a contributor to this splendid organization. American business concerns, philanthropists, and non-medical individuals are among contributors to the Medical Fund. It contributed about two and one-half million dollars to medical schools in 1953, of which the American Medical Association contributed $500,000 in addition to our individual contributions. Committee members have given freely of their time, but individual solicitation should be neither desirable nor necessary.

Do not neglect to send your pledge card and contribution to the American Medical Education Foundation, 535 North Dearborn Street, Chicago 10, Illinois. Our medical schools need help, and neither they nor we wish to be beholden to the government.

Presidential Address*

CHARLES RUGGERI, M.D.
Salt Lake City

IN ASSUMING the office of President of the Utah State Medical Association, I am deeply conscious of the responsibility placed upon me. With due humility, I shall endeavor to do the best I can to "promote and advance the art and science of medicine." In assuming this high office, I am also deeply conscious of the debt which we all owe to our predecessors in office. They have worked untiringly in our interest. At sacrifice of time and money, they have done their best for the welfare of our profession and in the interest of our people.

I am fully cognizant of the fact that the efforts of your present officers will meet with little success unless we all do our full share without stint. We each owe something to this great and wonderful country of ours for the privilege of being one of its citizens. We also owe a great deal to the great profession of medicine, of which we are a part. Let us do our full duty in both respects, and in so doing, leave the world a better place for our having lived in it.

These are exciting times in which we live, and fraught with great peril. Probably in no other period in its history has the world been in such a turmoil, and our country in such great danger. Great evil forces have been set loose which threaten the very foundations of our civilization—our way of life. At no other time has this great profession of ours, and we, as individual members of it, had such opportunities presented to us for service. We must be aware of our potentialities for good, not only to our profession, but to the people of our country.

I need hardly remind you that 1954 is an election year. Now is the time for us to expend more time and effort on behalf of better government and in support of those who value our freedoms. We need men and women in government who are sincere, efficient, and honest; men and women of courage and of vision; those who possess the fighting spirit of our forefathers; those who without fear will speak out for what is right and just. And unless we are prepared to surrender our freedoms, we must fight to remove those who do not measure up to these standards. We of the medical profession must dedicate our best efforts on behalf of our form of government, and accept our proportionate share of the responsibility of instilling new courage, initiative, and spirit in our people.

We must see to it then that we remain free men; seeking the truth unshackled. The quality and quantity of medical care must be improved; medical research and medical teaching must remain free; the individual's sense of responsibility for his own health and for that of his family must be preserved. The physician's sense of personal and moral responsibility to himself and to his patients must remain intact.

It has been repeatedly stated that our people enjoy the best medical care of any country in all the world; that scientific medicine has made such wonderful strides that we are living longer and more useful lives. Yet our public relations leave something to be desired. Is it because we have become mere technicians and have lost the art of the practice of medicine? If so, the way is clear. We must in our offices and at the bedside regain that lost art. Perhaps the administration of a good dose of sympathy, love, and understanding would have profound effect. Or is it possible that we are misunderstood? The medical profession has no moral right to allow itself to be unexplained, misunderstood and publicly distrusted—for its unpopularity poisons the pond in which we all must fish. As medicine

*Presented September 8, 1954, before the Sixtieth Annual Meeting of the House of Delegates, Utah State Medical Association, Salt Lake City.

becomes increasingly specialized, we must be understood by the public at large.

Don't Wait for Trouble

One fault of the medical profession is that it frequently waits until it is in trouble before worrying about its reputation. We are so preoccupied with the notion of practicing medicine that we often fail to recognize developing public relations problems until it is too late. Public relations is a long continued campaign aimed at moulding public opinion on a broad basis. There is no mystery in public relations. The secret is simply to tell all we can about ourselves, and to tell the story well.

But how can this be done when some are uninformed and apparently disinterested, perhaps for lack of time? One is amazed at times that so much can be said and written about the purposes, activities, and accomplishments of organized medicine without more of it having entered the consciousness of some members of our organization. It behooves us to take time, because good public relations is essential to the continuity and the advancement of medical practice. Here then is a wonderful opportunity for each one of us to do our part, so that we may be restored as leaders.

Under the inspiration and guidance of the Utah State Medical Association, a Water Pollution Control Act was passed by the Thirtieth Legislature. The Water Control Board, under authority of this act, was created in May, 1953. This board, in cooperation with the Utah State Board of Health, has been building up a staff of laboratory and engineering personnel. It has conducted studies of existing pollution levels in the State's water, and has made surveys of most facilities which result in discharge of pollution into such waters. It has adopted a set of design standards by which sufficiency of design of sewage systems and waste treatment plants may be judged prior to issuance of permits for construction of such facilities. It has tentatively adopted a set of water quality standards and a system of stream classifications to be used in classifying all streams of the State as to suitable uses and related permissible levels of pollution. Ultimately the Board will be in a position to begin issuing orders to all dischargers of pollution for construction of waste treatment plants which will insure preservation of suitable quality of all stream and lake waters.

Progress Against Pollution

In the meantime, the Board is requiring adequate treatment plants for all new sources of pollution in order to avoid aggravation of the present pollution. Nearly 400,000 residents of the State presently discharge untreated or inadequately treated sewage into the State's waters, and industrial waste already constitutes an even greater pollution potential.

The number of our citizens living in communities which have already completed, or have advanced plans for complete sewage disposal plants in the near future, has reached a total of 126,000. More of our communities are moving forward to solve their pollution and sewage problems without waiting for orders from the Anti-Pollution Board.

Three water-filtration projects are under construction, which, when completed, will supply safer water to 200,000 of our population. We are proud to have furnished the leadership for this project. It is an illustration of what responsible leadership and joint cooperative effort can accomplish. There is still much to be accomplished, however, and we must continue our efforts until the project is completed.

Let us discuss for a moment the problems of our public health services. Today in our State they are administered by at least four departments of our government. Less than 30 per cent of the money appropriated by our legislature for public health services goes to the Department of Health. Fifty-four full-time state employees (excluding those in our institutions, which are administered by the Public Welfare Department) are engaged in health activities outside the control of the Department of Health. Only seventy out of a total of 217 health officers in Utah are physicians. Such important functions as inspection of our food, milk, and milk products, and drugs, are performed by the Department of Agriculture. There are only three local health

departments in the State: Utah County, Davis County and Salt Lake City; and only one of these—Davis County—is served by a full-time health commissioner.

Here is a tremendous field for the medical profession to assert itself, and to assume leadership. We must expand our public health facilities to cover all sections of our State. In the new Health Code passed by the Thirtieth Legislature in 1953, permissive legislation was included whereby city and county, county and county, or counties, etc., could group together for public health purposes, and be administered by local district health departments.

Let us all be concerned with this problem, so that none of the people of our State shall be without proper environmental sanitation; so that we may have protection against communicable diseases; protection of our milk and water supplies, and that we may have proper examination of our foods.

A physician cannot continue to exist as an individualist. He must maintain pleasant working relations with his fellow physicians, with his community, with the allied professions, with the hospitals, with the press, and with the lawmakers who need guidance in regard to the health needs of the State.

Intra-professional Relations

Good intra-professional relations are closely related to good community relations. It becomes increasingly important for physicians to meet with citizens who have become interested in health matters. By assuming leadership in these discussions, it is possible for some of our members to develop fine community relations for the benefit of the entire profession.

Physicians are responsible for professional standards. Today, any physician, regardless of training, provided he is licensed, is privileged to undertake any surgical procedure, or to treat any complicated medical problem. The majority of our physicians undertake to do only those procedures for which they are competent. There are a few exceptions. It is the responsibility of organized medicine to protect the patient. This also presupposes a personal acceptance of responsibility. If we do not assume this responsibility individually, it must be assumed collectively or we will eventually lose our freedom. Anyone who selfishly violates the moral law thereby threatens our freedom. We must police our own ranks. We must do more than render lip service to our ethical and our moral standards.

Overcharging Must Stop

In plain language, what I mean is that any physician who is guilty of over-charging, over-treatment, incompetent treatment, or neglect of patients, must be controlled—disciplined—and if necessary, removed from our midst. We must either control ourselves from within or eventually we will be controlled from without.

As I assume leadership of this organization, I urge that more physicians take part in the preliminary discussions in meetings of the county societies, in discussions with our delegates; in meetings of committees. If you would express your ideas before decisions are made, decisions would probably be wiser. However, once recommendations have been made and the House of Delegates has considered them and arrived at decisions, the policies thus made should be considered binding on all of us. Let us all take part in the making of our medical policy decisions. Then let us really pull together as a team and gain that leadership that I have tried to describe to you.

Now, let us consider for a moment mental illness, our No. 1 health problem today. The preservation of mental health is a compelling and important immediate responsibility of the medical profession. A physician must become informed concerning the problems of mental health so that he can lend his skill and support to those measures that in any way give hope of preserving the mental health of our people.

About 6 per cent of the present population is suffering from mental illness. This means that roughly one out of every sixteen people is suffering from mental illness in a varying degree. About one in ten of our population is in need of psychiatric care. One out of every two hospital beds is occupied by a mental patient.

Too few of our membership at the present time appreciate the magnitude of the prob-

lem, and are unwilling to accept the responsibility of leadership. Consequently, the public is looking more and more to nonmedical disciplines both for therapy and public guidance.

Psychiatry in Its Infancy

We realize that scientific psychiatry is in its infancy and that little is definitely known regarding the natural history of most mental disorders. New knowledge is greatly needed to form the basis for future disease-prevention programs.

However, even with our present limited knowledge, more could be done to prevent mental illness than is presently undertaken. The problem is the concern of obstetricians, general practitioners and pediatricians, as well as the psychiatrists and Boards of Health.

A sound community mental health program should have a long range strategy, be wisely planned and effectively executed. A long term strategy based on a realistic understanding of what can be presently achieved obviates community programs, which shift with each changing season, as the fashion in mental disease presentation changes. One has only to recall the fields of mental health activities that have waxed and waned in the public eye. Juvenile delinquency, mental deficiency, marriage counseling, maternal and child welfare, and a list of others have received central attention for a period.

What is needed is a program with a firm foundation of planned relations with other community social agencies developed by contact in regard to problems of mental concern over a long period of time. Working alone without prior planning, preventative efforts are often superficial. Working together with a planned strategy of prevention through cooperation with all community social agencies, efforts are multiplied many times, and the deep impress of such efforts becomes a permanent part of the community character. There is a need for an organizing body with public and voluntary representation from public health, education, welfare and judiciary agencies. Let us assume the leadership and present to the communities of our State such a program.

Malpractice

The misunderstanding and the ill will engendered by the great number of malpractice actions has tended to break down the confidence of the public in the physician. It has been estimated that between 50 and 80 per cent of all actions for malpractice would be eliminated if thoughtless and inadvertent criticism of one physician of the work of his fellow physician could be stopped. What an ideal situation for the practice of the Golden Rule!

With respect to actual malpractice, we must recognize certain truths. When the moral and ethical standards of physicians are consistently high, there will be few instances of injury to patients resulting from ignorance, carelessness or culpability by professional people. However, even adherence to the highest possible moral and ethical standards will not eliminate all false claims. When physicians understand fully how to govern and protect themselves under the law, there will be few instances of injuries to them resulting from misguided, malicious patients.

There is no disagreement that proper records are essential for the benefit of the patients, and are the chief bulwark of defense whenever a claim of negligence or malpractice is made against the physician. A good record should contain sufficient data to justify the diagnosis, treatment, and the result. There is no acceptable excuse for any physician not having proper records.

Blue Shield Liaison

In 1935 the House of Delegates of the Utah State Medical Association organized the Medical Service Bureau. It was instituted as the physicians' own plan to improve the distribution of medical care, especially among the wage earners. While the plan has had its "ups and downs" since its inception, it has now grown to where it is the largest single medical-expense-carrier in the State of Utah. It has expanded from a surgical and obstetrical care plan to embrace many additional physicians' services. In the past eight years this plan has paid out nearly $3,000,000 in benefits to doctors.

As the plan becomes increasingly im-

portant economically to the physician, it is necessary that each individual member of our organization become more interested in the functions of Blue Shield.

The public is demanding increased coverage. The average American is interested in a single paid-up policy which pays all the medical bills. These and other problems will have to be met. It is important, therefore, that liaison be maintained between the Medical Service Bureau and the Utah State Medical Association. It may be well for the House of Delegates to consider having representation of the Blue Shield on the Council of the Utah State Medical Association to accomplish this purpose.

A profession which deals with the intimate problems of life and death must be alive, virile and dynamic. I am proud to be a member of the Utah State Medical Association, composed as it is of honorable, intelligent and reasonable men and women; an organization which is alive to the needs of the medical profession in the interest of better medical care for all our people. Let us present a united front in all of our endeavors, and let us strive to keep all of our activities, irrespective of the changing circumstances, under the control of reason, by which, alone, Man remains the judge of his own works, and after God, the master of his own destiny.

Diagnosis and Treatment of Hepatitis*

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THIS discussion is concerned with acute hepatitis. The term is used to cover the inflammatory processes in the liver aside from purulent reactions. Liver abscess and malignancies of the liver will therefore not be discussed. In acute hepatitis common presenting findings are jaundice and hepatomegaly. Hepatomegaly is not always present, nor is jaundice. Still this combination, with acute or recent onset, is usual and brings up for consideration as well those diseases with the same combination likely to be confused with acute hepatitis. Three such important conditions are: (1) Obstruction of the common duct. The 5 per cent of stones which are painless and carcinoma of the head of the pancreas are chiefly to be considered. They may be very easy or very difficult to differentiate. (2) Poisons or toxins. When these cause degeneration of the liver parenchyma, they may produce a diffuse hepatic process affecting liver function. (3) Exacerbations of cirrhosis. In older patients, especially those over 45 with a history of the use of alcohol, the possibility of chronic cirrhosis with an activation of the process by the alcoholic bout is possible. The historical information, together with other data in the examination of the patient, will often help differentiate this process. The term chronic hepatitis and its use in relationship to cirrhosis is confusing. By chronic hepatitis we mean a chronic inflammatory reaction. If fibrosis occurs along with it a cirrhotic process is said to exist. Cirrhosis therefore is not a single entity and may result from a number of types of liver damage.

Generally in inflammatory disease of the liver, the various structural units of the liver, the parenchyma, the Kupfer cells, and the vascular and biliary channels are all involved to some degree or other. Most important to remember is that in diffuse extensive disease of the liver, no matter what the etiologic type, the symptoms and signs are often based upon the acuteness and the degree of the process rather than upon the cause. Severe virulent hepatitis

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will produce rapid necrosis leading to destruction, shrinkage of the liver, and the development of yellow atrophy. If the process is less rapid, with some time for regeneration, a sub-acute yellow atrophy may appear. If the process is still less virulent the liver may become infiltered with inflammatory cells and fluid, and a large liver, accompanied by clinical jaundice, may appear with resulting recovery. The process may clear completely. It may also go through irregular repair resulting in fibroblastic activity and in the varying degrees of a scarring process or cirrhosis. The changes therefore may be based upon the severity of the change, the duration of the change, repeated insults, susceptibility of the individual, and the balance between destruction and response. Thus it is seen that toxic agents may often produce a clinical picture closely simulating that of acute infections. This is true of arsenical poisoning, carbon tetrachloride poisoning, sulfa reactions, and other similar degenerative processes. Here, the history may be important in differential diagnosis, and may be very important in therapy, for removal from the agent may be one of the most important factors in the treatment. These processes may simulate the picture of infection closely at times, and together with the flare-ups of old cirrhosis, have, in the past, been put into one large group under the term catarrhal jaundice.

There are a number of infections that may produce acute hepatitis. Some of these predominantly involve the liver. This is true of the viral agent or agents of infectious hepatitis and homologous serum jaundice, of leptospira, and of the virus of yellow fever. Amebic disease sometimes does the same thing.* There is also a group of infections in which hepatitis occasionally is an incident, but in which generally the infection is widespread and does not predominantly involve the liver. These include pneumococcal pneumonia, infections with the streptococcus, the Welch bacillus, and the typhoid bacillus. Syphilis, tuberculosis, infectious mononucleosis and malaria are also such examples.

Usually the two great groups of infections described above can be easily differentiated clinically. There are times when the general infection so expresses itself in the hepatic picture that it may be difficult to make the differentiation clinically. Of both groups the following entities are the most important to the general practitioner:

1. Acute viral hepatitis. This is commonly called acute infectious hepatitis and is the commonest cause of acute liver disease. It is ubiquitous, occurs in any area, at any age, and at any time of year. Outbreaks have on a number of occasions been related to the fecal-oral route of spread, but spread by personal contact has also been suggested. Generally diagnosis and treatment give little difficulty. But there are times when differentiation from some of the other acute varieties may be difficult, a matter often of importance because of variations in therapy. The disease homologous serum jaundice gives practically the same clinical picture. There are those who believe that these two diseases are the result of the same virus. However, differences in incubation period, in secondary spread of the disease, in immunity responses, and in mortality figures make some believe that they are separate and distinct entities. The terms virus A and virus B have been applied to the agents producing both of these diseases. Both give a clinical picture of jaundice commonly with hepatomegaly and usually with an acute clinical course lasting three to six weeks. In infectious hepatitis especially the onset may be characterized by chills and fever for several days before jaundice appears. In about 20 per cent of the patients the onset is insidious. In both, the complications in diagnosis and in treatment described below may appear. Active therapy is the same in both.

2. Infectious mononucleosis. This well known infection sometimes expresses itself predominantly in the liver. Such clinical

*The phase of amebic hepatic disease preceding abscess is called amebic hepatitis, a term often used clinically as well to cover clinical amebic hepatic disease in early stages of abscess, but before the latter state can be diagnosed. It is purely a clinical term as used here.

pictures are described in 1 to 15 per cent of the instances. In our own experience the figure is approximately 8 per cent. The liver may be palpable in 15 to 17 per cent of the patients, even when the clinical expressions do not draw attention to it. Liver function tests, especially the flocculation tests, are often positive with or without obvious liver change. Diagnosis is usually confirmed by an increase in the heterophilic antibodies in the blood or by the presence of atypical lymphocytes characteristic of this disease. To add to the confusion infectious hepatitis sometimes gives an increase in heterophilic antibodies. However, in infectious hepatitis the antibodies are not only low in titre but they are of the so-called "normal" type which can be absorbed by guinea pig kidney. In addition, infectious hepatitis may at times produce in the blood atypical lymphocytes which simulate those seen in the infectious mononucleosis.

3. Leptospirosis, or Weil's Disease, produced by Leptospira ictero-hemorrhagica, usually has its onset with fever and a systemic reaction. Jaundice usually appears and the clinical picture may simulate that of infectious hepatitis. However, the white blood count is usually elevated and there is very frequently severe involvement of the kidneys with the production of an albuminuria and at times elevated blood nitrogen. The disease gives remarkable generalized symptoms as well, sometimes involving the meninges. The organism can be demonstrated early in the blood and in the latter stages in the urine. Agglutination reactions are very helpful after eight to ten days. In many parts of the country it is said that this disease is not seen clinically. It occurs wherever rats abound, and is more common in work and occupations in which the skin comes in contact with rat urine. Thus it is seen in workers cleaning chickens or fish, particularly if rats come up into the area overnight and deposit their urine there, where workers may come in contact with it the next day. The hardy leptospiral organisms may be capable of producing infection if rubbed into the eye or taken into the mouth even after the deposition of urine is not discernible because of drying. The disease also occurs in sewer workers, in miners, and in workers in wet fields where rodents may contaminate the water.

4. Amebic hepatitis. This disease does not commonly give jaundice. Only about 10 per cent of the instances have clinical jaundice. The patient commonly has chills and fever with pain and tenderness referred to the right upper quadrant. The white blood count is elevated. There may or may not be a history of dysentery or diarrhea. In over one-half of our cases a history of diarrhea or dysentery was not obtained. Liver function tests may be positive. The flocculation tests are generally spotty.

In the above types of hepatitis the diagnosis and lead to diagnosis is based in large part upon clinical grounds. Details of history are important. For example the history of a transfusion or of the receiving of blood products two to four months previous to the development of jaundice practically makes the diagnosis of serum hepatitis. The details of colicky pain and other symptoms I will not mention. Liver breath, spider angiomata, and edema are helpful physical findings. Generally splenomegaly indicates parenchymal disease. About 80 per cent of the patients should be suspected and diagnosed by bedside methods. At times jaundice is not present. There are increasing instances of acute viral hepatitis, for example, in which jaundice does not appear, and the diagnosis must be suspected upon the presence of anorexia, epigastric distress, malaise, development of distaste for smoking, and unexplained fever with tenderness or swelling in the right upper quadrant.

Liver Function Studies

Although commonly done in all patients suspected of hepatitis, in about 20 per cent of instances diagnostic tests involving the liver function are important in diagnosis. They are helpful in establishing the presence of liver damage, but may not be of any great aid in differentiation of the

etiologic types. This must be done upon the basis of clinical findings and accessory laboratory data, such as the heterophilic antibody reaction, the white blood count, and so forth.

There are reports indicating that in viral hepatitis the liver function studies often become positive in certain order. This is said to be helpful in arriving at a diagnosis. It is true that the first test positive may be the bromsulfalein or increase in the blood bilirubin. Then the cephalin flocculation and finally the thymol turbidity test may become positive along with a change in the serum proteins and the alkaline phosphatase. It is said that in homologous serum jaundice the changes are more frequent before the development of jaundice. However, it is well to remember that the tests tell damage but not the agent causing it. They may not be taken at times best suited to allow their evaluation. Repetition of the same tests often increases their diagnostic value considerably. It is important to establish the presence of parenchymal disease of the liver, especially before jaundice appears or when jaundice is not occurring, and to confirm the clinical findings. Aside from being of basic help in diagnosis these tests are important in following progress to control treatment.

Liver function studies at times may be misleading. Of utmost importance is their interpretation in light of the total picture. The following four situations are examples of difficulties. 1. There may be primary diseases of the liver with little parenchymal damage, and consequent little change in liver function. This is true in the infiltrative types of cirrhosis. 2. There may be general diseases in which the liver function tests become positive. We have already mentioned pneumonia and infectious mononucleosis as examples. In congestive heart failure and in certain diarrheal states, especially chronic ulcerative colitis, some of the tests may become positive and mislead the observer into believing that there is primary disease in the liver. 3. Neoplastic disease may involve the liver with minimal changes in liver function so that the tests may not express the extent of the disease. 4. A confusing situation is the occurrence of homologous serum jaundice from transfusion or the use of blood products preceding surgery on the biliary system. The development of jaundice may make for difficulty in establishing whether there is a complication to the biliary disease for which the patient has been operated or whether hepatitis has developed.

The liver function studies in common use today are shown in Table 1. There are a number of such tests not shown on the chart. These include the blood iron, the cholinesterase test, electrophoretic determinations of the serum proteins, and others. However, Table 1 lists the tests in common use, arranged according to the generally accepted function measured.

Table 1
HEPATITIS
Commonly Used
LIVER FUNCTION TESTS

Related to Excretion	Related to Liver Cell Function
*Serum Bilirubin	*Flocculation and Turbidity Tests
*Urine Bilirubin	*Urine Urobilinogen
*Bromsulfalein	*Prothrobin Time
Alkaline Phosphatase	*Cholesterol—total and esterified
	Serum Proteins
	Hippuric Acid Synthesis

It is commonly said that no single test or combination of tests is satisfactory and that we must do a battery or profile. How can we sensibly select the tests and determine the number of them used? This decision depends upon (a) availability, (b) simplicity, (c) their value. Those in Table 1 listed with an asterisk represent a satisfactory group in the minds of many.

In the differential diagnosis of hepatitis and obstruction of the common duct, total abnormality of all the tests along with the clinical signs of anorexia and a palpable liver, would lead one to the diagnosis of hepatitis. If the cephalin flocculation and thymol turbidity tests were negative and the urine urobilinogen normal or low, obstruction would be favored. Peak excretion of urinary urobilinogen usually occurs

in the afternoon so that collection is best done at this time. In renal failure and after therapy with antibiotics affecting the intestinal flora excretion of urobilinogen may be diminished. Early in hepatitis values are usually increased with a decrease as jaundice reaches its height. It is then that obstruction is simulated. The other tests described above, together with serial determinations of the urobilinogen, which usually reappears in about a week in infectious hepatitis, generally settles the problem. In such tests as the cephalin flocculation reaction one must know the variability in the laboratory performing the test. When adequately done this test is of great value in the differentiation of obstructive and nonobstructive jaundice. The chief exceptions are in prolonged obstruction of several weeks' duration or concomitant cholangitis. The thymol turbidity test is not as sensitive as the cephalin flocculation procedure, and a reaction with serum lipo-protein components produces turbidity. Since serum lipids may be elevated in obstruction, the test may become positive in obstructive jaundice, but flocculation does not occur. Non-hepatic diseases affecting the gamma globulin fraction may produce flocculation, however. The test tends to be negative early in infectious hepatitis. The zinc sulfate turbidity reaction also follows the gamma globulin and is interpreted similarly to the thymol flocculation reaction.

In most patients seen in the general run of practice the prothrombin time is normal. When prolonged and corrected promptly by administration of vitamin K parenterally the test indicates obstruction. However, some patients with infectious hepatitis and prolongation of the time may show a return to normal after several days of parenteral vitamin K. Most important in favor of parenchymal damage is prolongation of the time not responding promptly to the vitamin.

Elevation of the alkaline phosphatase also suggests obstruction. However, there is so much overlap with parenchymal disease that the figure must be to 30 units or more to be diagnostic. Elevation in blood cholesterol, particularly if the esters fall below 60 per cent of the total, is in the same category. In general, the bromsufalein test, the blood bilirubin, the blood cholesterol, the prothrombin time, and the serum proteins, are not very helpful in the differentiation of obstructive disease. The prothrombin time occasionally is helpful if followed as already described, and the cholesterol if the deviations are striking. It is true that the direct blood bilirubin may be elevated greatly in obstructive disease and not in parenchymal disease. In the active stage of parenchymal disease the findings are usually equivocal unless followed serially. Generally in acute hepatitis it rises rapidly and in two weeks or so starts to fall off.

There are many instances when there is such overlap in the tests that a differential diagnosis cannot be satisfactorily established by them. This is particularly true in the older patients where there may have been delay in the diagnosis of obstruction, and damage to the liver has developed secondary to the obstruction. To operate on the patient with parenchymal disease may cause his death, and not to operate on him when obstructive disease is present may further the liver damage present. In general delay for a week or even two may be possible, practical, and less harmful to the patient than immediate surgery. Repetition of the liver function battery may then establish the diagnosis when a single investigation was equivocal. Even then it may be difficult, if not impossible, to differentiate obstruction from parenchymal disease upon the basis of the liver function tests alone. It is here that needle biopsy is sometimes helpful. This procedure is not frequently necessary, but it may be of great help in particular instances. Difficulty in differentiation of obstruction especially occurs in so-called cholangiolitic type of hepatitis, a variant of infectious hepatitis, in which evidence of cell damage is lacking and the findings are those of obstructive jaundice. Needle biopsy or surgery may be essential to settle the diagnosis.

It can be seen from the above statements that a minimal number of these tests may be useful, if properly chosen, in the differential diagnosis of obstruction and hepatitis. There is considerable irregularity in the results and this unsatisfactory state accounts for the great number of tests in common use. After the diagnosis is once made, the tests may be used to follow progress of the patient and to control treatment. Here the problems in the choice of tests are somewhat different and those are used which correlate with the patient's clinical progress. For example, in viral hepatitis the patient is usually kept in bed until the bromsulfalein test shows less than 10 per cent retention at 45 minutes, based upon a primary injection of 5 mg. per kilogram of body weight. The patient is also kept in bed until the blood bilirubin drops below 2.0 mg. and until the signs of liver enlargement and tenderness have cleared. If, on the patient's becoming ambulatory, these tests show increased activity or the liver becomes enlarged and tender, he is again put in bed. The cephalin flocculation and the thymol turbidity tests, on the other hand, may remain positive for a long period of time and are not suitable for gauging therapy in this way. In infectious mononucleosis, for example, the cephalin flocculation test may be positive for several months even though the patient has shown no clinical manifestations of an hepatic problem at all.

There is much discussion of the problem of chronic hepatitis following viral hepatitis and homologous serum jaundice. Generally the liver function tests become normal after about three months. If they remain positive in some degree after six months the patient is said to have chronic hepatitis. He may or may not have symptoms, and depending upon the tests he may show no evidence of damage, only residual damage or an active process. A few of these patients end up with a cirrhotic process which is irregular and commonly described as post necrotic cirrhosis. This process differs from the more diffuse type seen in Laennec's cirrhosis.

The picture of viral hepatitis is sometimes prolonged or fulminating in women after the menopause, in patients with malnutrition, in the older age group, in those inadequately treated, in pregnancy, after use of alcohol in the acute or convalescent stage, and after infections of other sorts appearing in the acute stage. In general complicating reactions and prolonged pictures seem more common in military than in civilian practice.

Treatment

The treatment of acute hepatitis is based upon a number of approaches. Much treatment of all forms of medical or parenchymal disease is the same. Generally surgery is contraindicted and is dangerous. The following categories are important to consider in the entire group:

1. Specific therapy. In most instances specific therapy is not possible for none is known. In amebic hepatitis the use of chloroquine or emetine according to routine schedules is desirable. In infectious mononucleosis and in leptospirosis certain agents, aureomycin or penicillin, respectively, are said to be specific, but there is no sound evidence for these statements. Leptospirosis was once treated with large doses of penicillin. Although suggestive results have been obtained in many areas, in general it is well established that penicillin is not a specific for leptospiral disease. The same may be said for aureomycin. In infectious monucleosis the use of aureomycin falls into the same category.

It is obvious that any toxic agent which may affect the liver should be eliminated. This is true whether the agent is the primary cause of the disease, as in carbon tetrachloride poisoning, or whether it is an hepatotoxic substance, such as alcohol, not primarly responsible for the clinical disease being treated. The use of alcohol is contraindicated in all states in which there is acute inflammation of the liver.

2. Bed rest. Bed rest is of importance in all acute hepatic inflammations. In infectious hepatitis and in homologous serum jaundice the patient is placed in bed in the

acute phase, often without any urging, for he may be nauseated, have fever, and demand the bed rest himself. When systemic symptoms have cleared the patient may be given bath room privileges and is kept in bed until the liver function tests, as indicated, return to a normal or near normal range in the presence of a non-tender liver of normal size. Some degree of ambulation is common in milder pictures in civilian practice.

3. Diet. Since World War II it has been generally conceded that a high protein-high carbohydrate diet is desirable in liver damage. This is true. At first there was reluctance to the addition of fats to the diet. At the present time is seems desirable to have a high protein-high carbohydrate diet with the protein content equalling about 20 per cent of the calories. Enough fat may be introduced into the diet to make it palatable. As stated above there should be no alcohol. Early in the disease, if the individual is nauseated and cannot eat, it may be necessary to give infusions. Following this if a full diet cannot be taken, a mixture of whole milk, with added skimmed milk powder, sugar, and eggs, can be made up, chilled and served throughout the day. This will cover satisfactorily the protein and carbohydrate requirements in the average patient.

4. Lipotrophic agents. In acute hepatitis there is little evidence that lipotrophic agents, such as methionine, choline, vitamin B_{12}, or crude liver extract have any place in the treatment as long as the diet is satisfactory in protein content. In chronic liver disease there are some who believe that these agents have a possible favorable anabolic effect.

5. Vitamins. It is customary to give the patient supplementary vitamins in the acute hepatitides. It is important that the vitamin dosage not be given in overload. There is experimental evidence to indicate that excessive amounts of vitimin B_1 may be damaging.

6. Sedatives. Care is necessary in the use of sedatives in patients with liver disease. Many patients get along satisfactorily on the usual doses of morphine and barbiturates. However, there are some in whom the deactivating processes in the liver do not function satisfactorily and ordinary doses of morphine or barbiturates may overact. Care in administration of these drugs is necessary.

7. Antibiotics. One would feel that statements on antibiotics should appear under specific therapy above. Such relationships have been discussed there. However, there have been some indications that in certain phases of infectious hepatitis, aureomycin or related compounds might be helpful. In the average patient with infectious hepatitis this is not true; in the serious fulminating cases which go on to precoma and coma aureomycin has been reported helpful. This may rest upon the basis of invasion of the liver area with organisms from the gastrointestinal tract, and their control with aureomycin. The drug under these circumstances has been used intravenously in doses not exceeding 40 mg. per kilogram of body weight every twenty-four hours in divided doses.

8. Cortisone and ACTH. The effects of these drugs have not been dramatic in any of the acute hepatitides. In infectious hepatitis they are said to shorten to some degree the course. Again they have been reported to be helpful in severe, down-hill types of hepatitis. Here they may help deposit glucose in the liver and are reported to delay the liver degeneration in experimental rats as well. However, there have been reports of patients who have become worse upon the drugs. Generally, as commonly stated in other infections, they are not to be used in acute hepatitis. There is one type of infectious hepatitis, the cholangiolitic type, in which these drugs are said to be beneficial.

Summary

An attempt has been made to evaluate the problem of acute infections involving the liver. The problems in diagnosis from the clinical standpoint and from the standpoint of laboratory investigation have been reviewed. The principles of therapy have been outlined.

Urologic Problems in General Practice*

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SOME urologic problem confronts the average practitioner nearly every day. For that reason it has been rightly stated that every general practitioner must be a urologist of sorts. The purpose of this presentation is to review briefly the urologic problems commonly seen by the general practioner and to offer suggestions in diagnosis and treatment.

Infection

Infection of the urinary tract is so common as to be encountered almost daily in general practice. Consequently, it is well to have a streamlined, logical, and effective approach to this problem.

Bacterial stain of the urine is the single most important step toward effective treatment. This takes but a few minutes in your own laboratory. See Table 1.

Table 1
FINDINGS ON STAINED URINE

Gram Stain	Methylene Blue
1. No Bacteria (Amicrobia)	1. No Bacteria
2. Gram Negative Bacilli	2. Rods
3. Gram Neg. Diplococci	
4. Gram Pos. Staphylococci	3. Cocci
5. Gram Pos. Streptococci	
6. Mixed Infection	4. Both

Amicrobia suggests virus infection, tuberculosis, interstitial cystitis and posterior urethritis in women.

Bacillary infections are first treated with one of the sulfas. Gram negative bacilli account for 80 per cent of urinary tract infections and the sulfonamides properly administered will cure 90 per cent of these. Thus, penicillin is said to be the most misused drug in urology.

Coccal infections are treated according to their group morphology since for each group there is an initial drug of choice. For Streptococcus hemolyticus, penicillin is preferred. For Staphylococcus, sulfa or erythrosulfa is advocated, since 70 per cent of present day strains are penicillin resistant. Streptococcus fecalis resists both penicillin and sulfa, mandelamine being the simple drug of choice. Gonococcal infections are treated with a combination of penicillin and sulfa.

Mixed infections have both rods and cocci in the stain and are treated initially by a combination of penicillin or erythromycin with sulfa.

Cases which resist a week of this preliminary treatment are likely to have foci of infection, urinary tract pathology that predisposes to infection or bacterial resistance. The more powerful and expensive antibiotics are withheld until these factors have been determined and, when possible, eliminated. As foci, teeth, tonsils, sinuses, ears, respiratory, gastrointestinal, and skin lesions predominate. Foreign body, calculus, and obstruction in the urinary tract notoriously predispose to infection. A scout film and an excretory urogram will generally disclose predisposing urinary tract pathology. Bacterial resistance is combated with the drug shown by sensitivity studies to be most effective against the organism cultured from the urine. Table 2 lists the common urinary tract pathogens. Directly after each organism is listed the simplest drug of choice for the initial week of treatment. Thereafter are listed the more powerful drugs that we have found by sensitivity tests and clinical experience to be most effective.

Acute Hemorrhagic Cystits

This occurs in both men and women and frequently follows an upper respiratory in-

*Read at 14th Annual Western Colorado Spring Clinic, April 24, 1954, Grand Junction, Colorado. Sponsored by Garfield, Montrose, Delta, and Mesa County Medical Societies.

Table 2
CLASSIFICATION OF BACTERIA

Group	Bacterial Name	Drug of Choice
Gram Neg.	Escherichia coli	Sulfa-Aureo-Strep - Pen where mixed
	Escherichia intermedium	Sulfa-Terra-Aureo
	Paracolon bacillus	Sulfa-Terra-Aureo
	Bacillus alcaligenes	Sulfa-Terra-Aureo
	Aerobacter aerogenes	Sulfa-Aureo
	Bacillus friedlanderi	Sulfa-Terra-Furadantin
	Pseudomonas aeruginosa	Gantrisin-Chloro-Strep-Terra-Polymixin-Neomycin
	Proteus vulgaris	Gantrisin-Chloro-Strep-Furadantin-Mandelamine
Gram Pos. Cocci	Staphylococcus aureus	Erythocyn-Aureo-Bacitracin-Mepharsin (Kid.)
	Streptococcus haemolyticus	Penic.
	Streptococcus faecalis	Mandelamine-Terra-Aureo-Chloro
Gram Neg. Cocci	Nieserrie gonorrhoeae (Gonococcus)	Penic.-Sulfa-Aureo

fection. In that instance Streptococcus haemolyticus is usually the etiologic organism and the treatment is penicillin with sulfa. When the source of infection is not from the respiratory tract, a bacillus is usually seen in the gram stain. A broad spectrum antibiotic is given for a few days, followed by a sulfa.

Posterior Urethritis and Trigonitis in the Female

This entity comprises the most frequent urologic problem of the female. It is most common in post-menopausal women. The diagnosis is suggested when tightness is encountered in obtaining the original catheterized urine specimen, when amicrobial urine is found, or when bacteria disappear on treatment but symptoms persist. One should not overlook the possibility of interstitial cystitis and tuberculosis with these findings. It is well to collect the original urine through a 24 French metal female catheter and look for tight areas in the urethra. Your first examination should also include inspection of the vagina and cervix as it will be impossible to control the urinary tract infection if these organs are feeding infection through the luxuriant communicating lymphatics, or if infection is flooding over the urethral meatus during menses.

Treatment consists of urethral dilatation and application of a topical colloidal silver medication, such as argyrol or protargol. At weekly intervals dilations are carried out, starting with a small female urethral sound the first week and progressing to size 26 or 28 French. A urinary analgesic in the form of a proprietary azo-dye such as pyridium or serenium may be useful. If the urine is strongly acid, it may help to alkalinize and, if alkaline, to acidify. "Bladder mixtures" containing a combination of the belladonna-like alkaloids and barbiturates are often useful antispasmodics for controlling frequency and urgency in the irritated spastic bladder. When the bladder capacity is markedly reduced to, say, below 150 cc's. a stronger anticholinergic drug such as Banthine or Probanthine may be necessary to reduce spasm and increase bladder capacity.

A markedly reduced capacity in a painful bladder that resists treatment suggests interstitial cystitis (Hunner's ulcer) and tuberculosis. Cases of Hunner's ulcer have pain on distention and relief on emptying, and may bleed profusely following overdistention — the clue being that fluid evacuated after the initial distention is relatively clear. Both of these conditions resist treatment and will require urologic consultation. Often the Hunner's ulcer case is subjected to useless pelvic surgery because the surgeon is misled by the patient locating the pain in the lower abdomen and the bimanual examination eliciting marked pain in the pelvic region.

If residual urine is present and the bladder capacity is abnormally high, the patient has a bladder neck obstruction or a neurogenic bladder and should be seen by a urologist.

Urethral Caruncle

This tumor is a proliferative inflam-

matory lesion near the urethral meatus, usually on the posterior margin. When the lesion is painless the patient's attention may first be arrested by observing blood on the toilet tissue. When infection is a complication, the caruncle may become exquisitely painful. Treatment consists of excision. Microscopic examination of the tissue is imperative, as it may be impossible grossly to distinguish caruncle from carcinoma.

Prolapse of the Urethral Mucosa

This condition is common in elderly women and young children. The mucosa is extruded through the meatus in a dark red doughnut that nearly always involves the entire circumference of the urethra. Treatment consists in eliminating sources of abdominal straining, including constipation and urinary obstruction. Urethral dilation, judicious cauterization, or excision may have to be resorted to.

Urethritis and Prostatitis

In the male our most frequent problem is *chronic prostatitis*. Often with this goes *non-specific urethritis*. The latter is a non-gonorrheal infection of the urethra with urethral discharge. If a man has a urethral discharge you'll soon be seeing him, because to him a discharge means venereal disease. Never agree in this diagnosis until a stain of the discharge is accomplished and then you are sure. For gonorrhea, two intramuscular injections of procaine penicillin at forty-eight-hour intervals and a sulfa drug orally for ten days is an effective form of treatment.

Acute prostatitis is not too common. It is recognized by exquisite tenderness over the prostate and vesicles on palpation, by fever, and by marked systemic symptoms. During the acute phase, massaging the gland is avoided. Antibiotics, hot sitz baths, hot rectal lavages, and opium and belladonna rectal suppositories are used. With this regime, prostatic abscess rarely develops, but if it does occur, it must be surgically drained.

In chronic prostatitis the gland is congested, boggy, tender, and the expressed fluid contains numerous leukocytes and at times bacteria. An abnormal secretion may not be obtained until after the second massage. Dysuria, perineal pain, and *lumbosacral back pain* are more common but symptoms may be limited to a below par feeling with excessive fatigue. Examination should include plain x-ray over the bladder and prostate to rule out calculi. Urethral calibration for strictures and a check for residual urine should also be done. Strictures predispose to both urethritis and chronic prostatitis.

Treatment consists in carrying out weekly prostatic massages, administering an antibacterial agent, and daily hot sitz baths. The patient is placed on a bland diet, and instructed to abstain from alcoholic beverages during the treatment period. Choice of the antibiotic depends on the infecting organism. Patients with strictures must have progressive dilations at varying intervals. Sinuses, tonsils, and teeth are frequent foci of infection that must be eliminated. Edentulism does not exclude a dental focus. Dental x-rays are necessary to rule out an apical abscess or root fragment with abscess.

The success of your treatment largely depends on prostatic massage properly executed. Our experience would lead us to believe that this is rarely done. A gentle massage more often than not only serves to aggravate the condition. Firm pressure with the ball of the index finger is applied over all areas of the gland, stroking with a slightly medial rotary motion from the upper pole of the lateral lobe downwards toward the apex at the midline. Special attention is directed to areas which are indurated, as these represent areas with blocked ducts. In all instances the seminal vesicles are stripped. The massage should not take longer than thirty seconds nor should it cause excessive pain. Treatment is continued until the white count in the smear falls to near normal limits. Massage should never be done more often than twice a week and in no case should massages be carried on indefinitely. A six-week rest period is necessary after each treatment

period of six to ten weeks, regardless of the cell count. If this regimen does not produce satisfactory response, recheck for foci and urologic consultation are appropriate.

Strictures

Urethral stricture is usually best left to the urologist for no other situation gets the occasional instrumentor into so much grief. A sulfa or antibiotic is given two days before and two days following dilations in those cases that customarily experience febrile reaction to instrumentation. "Gentleness" is the byword. Never force a sound or rigid instrument. Use rubber catheters to dilate when possible. When the urethra is pocketed, angulated, or where false passages exist, it is best to pass filiforms to locate the proper channel and follow through with Phillips woven catheters. Acute urinary retention may dictate your course of action. You may only be able to introduce a small Coudé tip catheter or a tiny filiform. One shouldn't be over ambitious at this point. It is best to simply tape this small instrument in place and wait for it to soften the stricture. Within forty-eight hours you will be able to pass a much larger instrument easily. In the meantime the patient will be able to empty even with only a filiform in place.

Meatal strictures occur in some degree in 5 per cent of small boys and in many adults. Meatotomy is carried out with or without anesthesia, depending on age. The important point is to keep the meatus *well dilated* by having the parents insert a plastic meatal dilator well lubricated with an antibacterial ointment two or three times a day for the two-week healing period. The pin-hole meatus in a child may cause an insidious retrograde dilation of the entire urinary tract. Symptoms may be entirely absent, so always test for residual urine.

Enuresis

Enuresis in one out of every eight cases in boys will be attributable to serious urologic disease—usually obstruction. So examine them carefully. Look for meatal stenosis and other stenotic areas. Many lay articles have been written on this entity, so don't tell a mother the child will outgrow this calamity until all pathology has been ruled out.

Circumcision

Circumcision is a common procedure being done all too often in such a manner as to require subsequent revision. The common errors are to remove too little or too much. A simple and accurate way to avoid these errors is to mark out the two proposed skin incisions, using the coronal sulcus as a landmark. First, with the prepuce in its natural pulled down position, the outer incision is made to circumscribe the outer skin leaf just proximal to the coronal sulcus. Then, with the prepuce retracted the inner incision encircles the corona, leaving three-sixteenths inch margin of mucous membrane. The intervening skin is then excised, using blunt tipped scissors dissection just beneath the skin in a relatively avascular area.

Hypospadias is a condition not usually treated by the general practitioner but is here mentioned only to sound a word of caution in connection with circumcision. Never under any circumstance circumcize a patient with hypospadias. In those instances the prepuce which is present in the form of a dorsal hood will later be sorely needed as a source to supply a natural, soft, elastic, hairless skin for plastic reconstruction of the absent segment of urethra.

Intrascrotal Lesions

In skimming over intrascrotal pathology, testicular tumor and torsion of the spermatic cord deserve particular attention.

Testicular tumor. In testicular tumor the onset is insidious but the rate of growth may often be explosive. Occurring most commonly between the ages of 20 and 35, the diagnosis is most often confused with hydrocele, hematocele, and epididymorchitis. These tumors may or may not be painful and tender. They may be smooth or irregular. They are characteristically "heavy" and this heaviness is probably the single, most consistent characterizing physical property of a malignant testicular tu-

mor. An inflammatory hydrocele may coexist about a malignant tumor and obscure the diagnosis. Here the heaviness or transillumination may provide the tip-off to the correct diagnosis. In doubtful cases aspirate the hydrocele fluid and re-palpate. If after transillumination and palpation you cannot be *completely* sure that the scrotal mass is not malignant, immediate consultation should be insisted upon. Don't temporize! Bear in mind that testicular tumor may be the most rapidly fatal of all malignancies. Whenever the slightest possibility of malignancy exists, the urologist is duty-bound to recommend surgical exploration through a high incision, at which time he must be prepared to execute a radical orchiectomy if malignancy is found. Biopsy is condemned.

Torsion of the spermatic cord will not often be encountered, but it is important because if it goes unrecognized for more than six to eight hours, the testicle will be lost. Torsion most commonly occurs between the ages of 14 and 25. It is most often confused with acute epididymitis, but may be distinguished by the very sudden and painful onset often associated with strain or physical activity, exquisite tenderness, high-lying position of the testes, lack of associated inflammation in the seminal tract or prostate, lack of fever, and lack of pus in the urine. Whenever doubt exists as to the exact diagnosis, *immediate surgical exploration* is indicated. If torsion exists, the opposite testis should also be exposed and anchored to the scrotum, because torsion is so often a result of a congenital defect in attachment on both sides.

Epididymitis

In cases of recurring subacute and acute epididymitis of more than three attacks and in persistent chronic epididymitis, unilateral vas ligation or epididymectomy is often the only cure and surgery should be resorted to. This is especially so in men on the upper side of middle age whose families are numerically well established.

Cancer of Prostate

In all the field of urology the general practitioner faces his greatest opportunity and responsibility in detecting early carcinoma of the prostate. The reason for this is twofold—first, the extremely high incidence of cancer of the prostate, and second, the extremely low incidence of early discovery in that stage of the disease in which a surgical cure may be expected. For practical purposes we may assume that one of every five males over the age of 50 has carcinoma of the prostate. See Table 3 which shows the incidence of cancer found in prostates of men over 50 in two series of autopsies by different investigators.

Table 3
INCIDENCE CANCER OF PROSTATE IN MEN OVER 50 YEARS

Author	No. of Cases	Method of Examination	Per Cent with Cancer
Moore 1935 (J. Urol.)	229	(Step Section (4 mm Steps)	20.5
Rich 1935 (J. Urol.)	292	Random Section (One random section through each prostate)	14

Obviously, it would be wise to do a rectal examination every six months on every man past the age of 50. Certainly any physical examination is poorly done without it. Carcinoma is most generally recognized by its stony hard consistency and by areas of nodularity. Other less definite signs are variation of consistency without classical induration, asymmetry, periprostatic fixation and early periprostatic infiltration. Ninety-five per cent of well established carcinoma of the prostate can be diagnosed accurately by rectal examination. But this is not good enough since 50 per cent of these will already show evidence of distant metastasis.

It is in the group of glands showing early and questionable induration that our hope of diagnosing and curing cancer lies. Experience has shown that when there is reasonable suspicion about malignancy, 50 per cent of those glands will prove to be carcinomatous. Most of these can be cured by radical extirpation. Therefore, let us here and now resolve to refer any suspicious prostate to the urologist for *early* evaluation; and in turn, let those who work

Table 4
CLASSIFICATION OF CARCINOMA OF PROSTATE

Group	Incidence	Curability	Anatomic Features	Treatment
I	5%	Potentially curable	Confined within prostate capsule	Radical prostatectomy
II	45%	Formerly incurable	Local extension without distant metastases	Radio-active Gold
III	50%	Incurable	With distant metastases	Palliative

in that specialty not be timid. Be quick to biopsy if there is the slightest doubt. A transperineal needle biopsy is so easily and quickly accomplished. It keeps the patient in the hospital less than twenty-four hours.

For treatment purposes we classify carcinoma of the prostate into three anatomic groups. See Table 4.

In group I cases the cancer is confined within the prostatic capsule and extirpation offers a surgical cure.

In group II cases the malignancy has infiltrated locally into surrounding structures but there is not yet distant metastases. About 45 per cent of carcinomas fall into this group. Until recently admitted to be incurable, we can now offer hope of control or clinical cure for this group if we employ interstitial irradiation. Radioactive colloidal gold (AU 198) is injected throughout the cancer tissue creating billions of point sources of irradiation for its destruction. For this we employ a heavy lead protected, power-geared injecting syringe to obtain even distribution of the radioactive particles. To date we have obtained very encouraging results with this new mode of therapy.

Group III cases are those with distant metastases. They are treated palliatively with orchiectomy and estrogen therapy.

Hematuria

Malignant tumors of the kidneys, ureters, and bladder may be discussed in one group under the heading of hematuria. Gross, total, painless hematuria indicates malignancy in 90 per cent of all instances. Without exception, the first episode of gross hematuria should require a complete urologic explanation. Not a guess—but accurate knowledge. Procrastinating here again is placing in jeopardy your patient's life. Sure, the bleeding will stop spontaneously or when you give an antibiotic. And the *cancer keeps right on growing!* Look at Table 5 which compares the five-year survival rates of people with these malignancies against how many episodes of bleeding occurred before treatment was instituted.

Table 5
FIVE-YEAR SURVIVAL RATES IN URINARY TRACT MALIGNANCY
(Based on Number of Episodes of Bleeding Occurring Before Treatment)

Number of Episodes	Per Cent Five-Year Survival
1	90
2	40
3 or more	10

Note how the survival rate drops precipitously when the patient waits until the second and third episode of bleeding. It is urgent to examine for gross hematuria during the very first hemorrhage.

Distribution of blood in the voided specimen often gives a good lead as to its source. See Table 6.

But don't guess. Try to have the patient cystoscoped while he is bleeding actively!

Summary

An attempt has been made to cover briefly the urologic lesions seen most commonly in general practice. In addition, emphasis has been placed on four important points regarding malignancy:

1. Any testicular mass raising the slightest question of malignancy should be referred immediately and an early exploration done if necessary.

2. Men past 50 should have the prostate

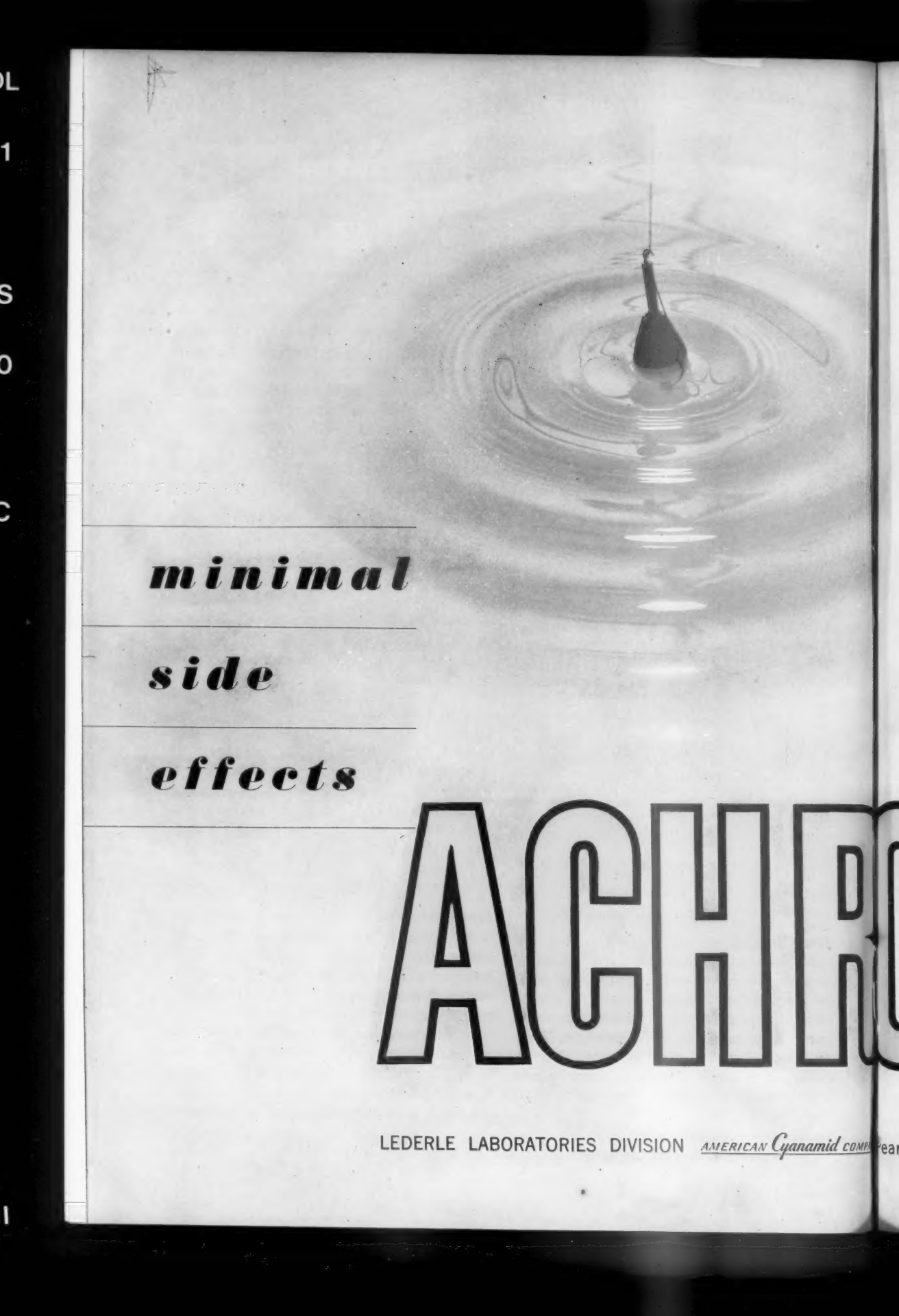
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Table 6

ANATOMIC SITE OF BLEEDING DETERMINED BY DISTRIBUTION OF BLOOD IN VOIDED SPECIMEN

Type	Distribution	Likely Site of Bleeding
1. "Urethral"	Bleeding without urination	Urethra distal to sphincter
2. "Initial"	Heaviest in first glass	Urethra or prostate
3. "Total"	Evenly distributed in all glasses	Bladder or upper urinary tract
4. "Terminal"	Heaviest in third glass	Bladder wall (as in cystitis)

checked for cancer twice a year and on every physical examination. Any suspicious lesion should be studied with benefit of biopsy.

3. Any patient having even one episode of gross hematuria deserves a complete urologic check to rule out malignancy.

4. The general physician and surgeon are the first to see these people and it is upon their shoulders that the responsibility rests.

*The Nose in Your Life**

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THIS title was chosen to point out the importance of the nose in yours and everyone else's life. Like such other important commonplace things it has been, and often is, neglected. Most of us take the nose for granted. We simply think of it as an organ wherein the sense of smell is located and through which we breathe. This paper will discuss the nose, particularly as to its job —what it does and how it does it. This subject is rarely mentioned in our circle; it is not even described in any standard textbook on physiology. It is almost as though it were "verbotten," a forbidden subject to talk about in polite society, like sex used to be.

However, literature, history, folklore, and expressions in modern English usage which involve the nose, show it has a definite meaning in our lives and times. For example, the size and contour of the nose have been held to be trustworthy indicators of personal characteristics. Napoleon Bonaparte always chose men with large noses for important missions. Pascal who lived in the Seventeenth Century wrote of Cleopatra's nose: "If the nose of Cleopatra had been shorter the whole face of the earth would have been changed." And what did Rostand have Cyrano de Bergerac say? "A great nose indicates a great man, genial, courteous, intellectual, virile and courageous." The Tahitians however, consider it an insult to be called long nosed. A flat nose was an object of prejudice among the patriarchs of Biblical times, though later, in the time of Attila in the fifth century it was the practice of the Huns to flatten the noses of babies by bandaging. The Eskimos, as well as certain tribes of Indo-China, Burma, and Malaya use the nose in salutation by rubbing noses, described by observers as a salute by smelling or sniffing. In Folklore they describe a treatment for the common cold as good, perhaps, as any we have today. It is the cure of a cold by kissing the nostrils of a mule. Expression in modern English usage such as "the nose

*Read at the Annual Meeting of the Wyoming State Medical Society, Sheridan, Wyoming, June 8, 1954.

knows," "right on the nose," and "won by a nose" and many others, mean something definite to almost everyone and that meaning gives a different connotation to the nose than its simply being an organ of smell and breathing.

There are some other interesting things about the nose. Unfortunately it is the only organ that keeps growing throughout life. It never stops. Furthermore, the rhinencephalon, the cerebral nasal counterpart, has some unusual characteristics. It, too, is the only part of the central nervous system center which is continuing to develop in man. It is a sort of depot or arranging center for all cerebral activities.

Nose doctors for generations have been struggling with and studying nasal structures and anatomy in minute detail, and have struggled almost as hard to avoid learning anything about function and the physiology of the nose. Some workers, notably Proetz in this country, have described beautifully the air currents, perhaps I should say redescribed, as most of the work on air currents appears in the German literature of the Nineteenth Century. This work, however, has left us dangling. We know where the air goes, but not why or how. Most research in our field on nasal physiology has not been explained, and that is the importance of the necessity for a new concept in rhinological physiology, particularly as it applies to surgical treatment.

The last six or seven years a group of otolaryngologists have been meeting at least once and usually two or three times a year under the tutelage and guidance of Dr. Maurice H. Cottle of Chicago. He is responsible for most of the renewed interest in the subject as to the role of the nose in our lives. His work with this group has stimulated a great interest in this subject and he is the authority for most of the statements in this article.

Each individual structure—the lobule, the septum, the dorsum, the upper lateral cartilage, and the vestibule—has, of course, a definite anatomy and also a definite function. Each performs its function independently but also has to correlate that particular function with the over-all function of the nose. Why do we have a nasal septum? We don't believe the Good Lord designed the nasal septum, for instance, to be a landing field for eager submucous surgeons. It must have some other function. We doubt if the Lord would go to all that trouble just for the benefit of a relatively few people who can and do earn their living doing submucous resections. Is it a simple partition to divide the nose into two parts? Actually it divides the nose into two separate and distinct noses. Why is it hard, semihard, and soft in different areas? Why it is a fixed solid structure, a semi-mobile, and a mobile structure in different areas? What are the functions of the lobule, the vestibule, the upper lateral cartilage? Why is the upper lateral cartilage a firmly attached, integral part of the septum in its cephalic portion, loosely attached, and even without attachment, at its caudal portion to the septum? Why does the angle of its attachment at the midline become more acute as it descends from the nasal bone level to its inferior attachment near the caudal end of the septum? Why do we have a naso-thoracic reflex? How do the air currents actually pass through the nose? Why is nasal breathing superior to mouth breathing? What regulates the volume, velocity, direction, eddies, and intranasal pressures of the air currents? Most important of all, why must we have resistance in the nose for good breathing? What happens when one or more of these structures does not do its particular job?

The functions of the nose are usually listed as respiratory and olfactory, with secondary functions as phonatory and gustatory aids. Carrying this one step farther, some of us believe it is also an organ of well being, or good living. A study of nasal structures is important but only as they pertain to activity and integrated function of the nose and even the body as a whole.

As air passes through the nostril it enters that part of the nose called the vestibule. This is a skin lined lobby through which the column of air must first pass to enter the nose proper. The vestibule is

guarded by two sentinels protruding into its space. The one medially is the terminal end of the medial crus of the columella, and the lateral one is the lower lateral border of the lateral crus. These sentinels guarding the entrance into the vestibule we shall hereafter refer to as "baffles." They are the first resistors and traffic directors for the column of air entering the nose, and actually the beginning, we believe, of nasal physiology. There are in addition to these two "baffles" several other important ones, namely the caudal border of the upper lateral cartilage, the cul de sac (the soft tissue connecting the upper and lower lateral cartilages), the vibrissae, and anterior tips of the inferior turbinates. We believe that these "baffles" are extremely important in preparing the column of air for entrance into the nose proper. They split the column of air into sheets or lamina and after passing to the upper lateral cartilage "valve," that we will speak about later, the air, due to the action of the "valve" and lobule of the nose, rises to the upper regions of the nasal chambers where we find not only a stimulation of the olfactory nerve endings but also the afferent nerves of the nasal thoracic reflexes are stimulated. In addition to this we find that the nerve endings of the fifth, seventh, ninth, and tenth cranial nerves come in contact with the air current. It is only when all these nerve endings are stimulated that the patient has the feeling that he is breathing well, and of well being.

Where the upper lateral cartilage at its terminal end joins the septum we have a fibrous union and in some cases no union at all. Here is where the major part of our concept of physiology comes into being. At this fibrous junction we have a definite valve action, the ability of the upper lateral cartilage to swing towards or away from the septum. Here as we look into a normal nose we see only a slit-like passage through which the air must pass. This increases the pressure with which air is received and with which air is expelled through the nose. This upper lateral cartilage valve is affected directly by action of the lobule.

The upper lateral cartilage which forms this valve is so important that we must visualize its anatomy thoroughly. It is, as we mentioned in the anatomy, attached to the under surface of the nasal bones. This attachment is a gentle one, by loose connective tissue, and of importance in injury, as we will describe later. Actually the upper lateral cartilages are wings of the septum, but of great importance is the gradual but definite change from an acute angle at its caudal fibrous attachment to the septum, to an obtuse angle at the nasal bones. It is by this attachment that we have a definite valve formation that allows the upper lateral cartilage to swing closer to the septum on inspiration and away from the septum on expiration.

What is the function of the septum? Anatomically it actually creates two noses. This, according to Cottle, allows one side to rest while the other side does the work, as during sleep. The hard portion of the septum serves the primary function of resistance to the air stream. It aids in the formation of the dorsum and helps support the upper lateral cartilage. We also feel that it is the medial terminus for the rhythmic excursion of the turbinates which aids in the control of the velocity of air currents. The semi-mobile portion is part of the valve. It supports the respiratory epithelium. So we have a direct relationship of the septum to all the structures of the nose.

We have repeatedly mentioned resistance in the nose as being so important in respiration; why? Here is a relatively small caliber "tube," so to speak, imparting 46 per cent of the resistence of the entire respiratory tract. It is because muscle action per se depends on the resistance or load against which it must work or overcome. In respiration it is this resistance offered by the nose which puts a load on the accessory muscles of respiration and we have initiated the enlargement of the thorax and the breathing cycle. In normal quiet respiration this is, of course, an automatic function; but what takes place when there is the need for more oxygen intake, such as in exercise? It is the all important upper lateral cartilage valve and lobule

which by its delicate mechanism of "closing in" and narrowing its angle to the septum when the oxygen need is greater that increases the resistance by simply narrowing the canal and offering a greater work load to the accessory muscles of respiration. As a result they must contract still more to overcome the increased resistance offered with a resultant increase of oxygen intake. Furthermore, as you all know, every reflex action must have what is known as a reaction time, so that the baffling and slowing up of the air currents gives time for the reaction time vital to the nasal thoracic reflex. If the air rushed through the nose, as it would were it a simple tube, no such time would be provided. As it is, however, the eddies of air waft, so to speak, over the nerve endings and thereby sets the reflex mechanism in action.

We also feel that position, size and direction of the nares are important from a functional standpoint. Abnormality of the nares can definitely alter and misdirect the air currents. We find, then, a multiplicity of factors that enter into and share individually and collectively in the passage of the air currents from the nostrils to the respiratory tract. The baffles, lobule, upper lateral cartilage valve, septum and turbinates all play their important roles in imparting direction, volume, velocity, resistance, and stimulation of the cranial nerve endings in the problem of respiration.

The primary purpose of nasal surgery, whether we are dealing with the septum, the lobule, upper lateral cartilage, external nasal pyramid, turbinates, or any other nasal structure is the restoration of a properly functioning nose. Only secondarily are we concerned with cosmesis. In the consideration of cosmesis, however, we are faced with a definite challenge. First is the maintenance of the physiological norm when it is present and its restoration when it is impaired. Second is the evaluation of the patient from a psychiatric point of view in the reconstruction of a "new nose." When we are faced with the problem of reconstruction or rhinoplasty, and before we operate on a patient, it is, of course, necessary to understand the four W's, "who, why, when, and where." Who is the patient? Why does he come to you? When should you operate? Where on this patient do you start and finish your operation, keeping in mind that this is not simply a nose, but a human being subject to all the trials and stresses of modern-day life? He is a sick person with a sick nose. In a psychiatric study conducted at Columbia University, it was found that 75 per cent of those patients having a functional disturbance also had facial deformities and in the greatest per cent the nose was the offending agent. We hear much these days of psychosomatic medicine and it is well to remember this is a two-way street and often it is somatopsychic. A good number of your patients who complain of nasal symptoms or headaches, post nasal drip, et cetera, really want a nose operation. Many of them will not, for obscure and even often subconscious reason, admit it. They refuse to face the fact, but experience shows that their ultimate desire is to have a good-looking nose. It is interesting and informative to ask your patient, first, before the surgery starts, while he is on the table and more or less under the truth-telling effect of the barbiturate premedication, just what he wants you to do for him. Nearly without fail he will say, often for the first time, "Take the bump off, Doctor" or "Straighten my nose." You all agree it is important to know why the patient comes to you and it is also important to be able to do the something that he wants you to do as long, certainly, as it is within the realm of legitimate surgery and will improve function and structure. Many years ago Sir William Osler, the great teacher and philosopher of medicine, laid down a well-known dictum: "It is better to know the patient that has the disease than to know the disease that has the patient." We believe we can paraphrase Osler and safely say, in the study of rhinology, it is equally important to know the patient that has the nose, as well as the nose that has the patient. That is the field of rhinology which has not even been scratched, although from your own experiences you know that thousands of patients have com-

plained that it itches. You owe it to your patients to at least scratch the surface, so to speak.

Only of recent years, basing our surgical approach on the physiological requirements of the patient, has nasal reconstructive surgery made its great strides. Rhinoplasty or nasal reconstruction solely with the cosmetic end result in mind leaves in its wake, only too frequently, nasal cripples. On the other hand, too many of our patients have been, and are being, subjected to the classical submucous resection described over fifty years ago by Dr. Freer. It is an operation that has, to be sure, its place in a relatively small percentage of patients. Although the technic has been revised many times the entire philosophy of the classical submucous resection has never been revised, reviewed, or understood. For over fifty years we have had "a nose operation" held in ill repute by the laity and medics alike.

Too long have we been misguided by the wrong conception of the relationship between anatomic deformities and physiologic difficulties. It has only been in the last decade and that primarily through the efforts of one man, Dr. Maurice Cottle of Chicago, that we rhinologists have had the opportunity and have been shown and taught an entirely new concept of reconstructive nasal surgery based primarily on physiologic need. He has shown us that when one part of the nose is wrong we must correct that part only in its proper relation to the other parts of the nose. To do the old classical submucous resection of the septum and ignore adjacent structures such as the turbinates, upper lateral cartilage and lower lateral cartilage and lateral wall of the nose and roof can spell disaster. No wonder any operation on the nose is looked at askance by so many people. We must stop neglecting our responsibilities! When a patient tells us, and very frequently shows us, that by tilting up his nose or by pulling on his cheek "to open up his nose," that he can breath better, he has pointed out his difficulty and we cannot cure him by the classical submucous resection! That patient has told us that the lobule of his nose and upper lateral cartilage of his nose are "guilty" and that the valve action of the upper lateral cartilage is impaired and must be reviewed, revised, and reconstructed. Unfortunately those are the patients that have been subjected to the submucous resection and have been peddling the truth, I am sorry to say, about not having "a nose operation."

In summary, we have tried to cover a large field of rhinology in a short time. We realize in the attempt to cover this field we have oversimplified the problem and if we appeared didactic that it was only for the necessity of brevity in the discussion. However, we have emphasized the normal anatomy and tried to tie up the anatomy with the physiology. This new concept of physiological nasal reconstruction is only in its infancy. We must remember that we have been at a standstill for over fifty years in nasal surgery and much more has to be learned before the final word is spoken.

NEW MEDICAL TV SHOW—"MEDIC"—ON NBC-TV

Of special interest to all TV-viewing physicians is NBC-TV's revolutionary new program, "Medic," which was first beamed across the country September 13. Sponsored by the Dow Chemical Company, this new "Dragnet"-type show will bring to millions of Americans a better understanding of the role of modern medicine in their daily lives.

A dramatic, informative and authentic program, its various doctor-patient sketches touch on all phases of life, both historical and contemporary. No single character will run through the series, but medicine itself will be the "star."

"Medic" is being presented Monday evenings at 9 p.m. EST, three times monthly. Producers are ex-"Dragnet" writer James Moser and veteran TV and stage producer Worthington "Tony" Miner. The Los Angeles County Medical Association will lend technical assistance.

The Medical Management of Uncomplicated Peptic Ulcer*

H. Ivan Sippy, M.D.
Chicago, Illinois

THE first, and most obvious, goal in the management of peptic ulcer is to attain rapid and complete healing. The second, and less frequently recognized, objective is to accomplish this in such a way that recurrence becomes unlikely. Thanks to the natural reparative tendency in benign lesions, temporary healing of peptic ulcer may occur spontaneously, or after faulty methods of treatment. Such a result is seldom lasting, and recurrence is to be expected. Good management must go beyond the initial healing of the lesion, to assure a high percentage of permanent cures. Thus, no form of treatment can be evaluated until the results have been under scrutiny for many years.

No completely satisfactory solution to the peptic ulcer problem has yet been found, for numerous reasons. Chief of these is the lack of knowledge of a specific cause against which we might provide a specific treatment. Were there a known infection, or hormone deficiency, or other forthright basis for this disease, we could hope to invoke the miracle of the wonder drugs, or endocrine therapy, or other modern innovation, to effect a true cure.

Lacking specific weapons against an unknown adversary, we must content ourselves for the present with methods which attack the factors opposing healing of the lesion—namely, the acid-pepsin secretion. A literal interpretation of the "no acid-no ulcer" concept will give us a sound basis for such an attack. Dissuasion from accurate therapy often results from the ease with which ulcer distress can be silenced by the sketchiest of treatments. Such symptomatic relief from inadequate measures leads the patient, and often the doctor, to be content with mere palliative measures, rather than a purposeful regime which could bring permanent recovery. The confusing flood of "cures" which are endlessly proposed to physicians and to the public is another deterrent to sound treatment. Attracted by the flare of each new enthusiastic report, ulcer sufferers are prone to try one scheme after another, to the point of discouragement with all forms of treatment. Defeatist philosophies of the "learn to live with your ulcer" type—based on ignorance of the possibilities of good treatment—have received wide publicity, and create resistance to the acceptance of sound principles of therapy.

Eager public interest in the psychosomatic approach to illness has led many ulcer sufferers to accept the fallacy that they are victims only of their emotions or imagination. Thus they are misled into rejecting sorely needed somatic treatment—as great an absurdity as it would be to deny that psychogenic factors have an important part in the aggravation of ulcer symptoms. Insistence on newly-discovered therapeutic agents has become a fetish, and in this thoughtless grasping for new methods, established principles are often forgotten, or unjustifiably abandoned. The patient who demands, and often gets, "something new" in treatment, may receive a far less effective campaign against his disease. Remembering again that no treatment is worthy of acceptance unless its outcome has been under surveillance for many years, let us now return to a consideration of fundamental principles. We must go back forty years to review a concept of ulcer management which has stood the test of time, and which still offers the foremost prospect for immediate and lasting success.

In 1915, B. W. Sippy presented his best-known report on the results of ulcer man-

*Read at the Annual Meeting of the Wyoming Medical Society, Casper, Wyoming, June 12, 1953. The author is Assistant Professor of Internal Medicine, Northwestern University Medical School.

agement by complete neutralization of the hydrochloric acid of the gastric juice. Conceding that this method did not strike at the unknown basic cause of peptic ulcer, he nevertheless contended that a high percentage of lasting cures could be accomplished by the complete elimination of acid-pepsin corrosion. He made it clear that the proteolytic action of pepsin is a powerful preventive of healing in the presence of even small concentrations of hydrochloric acid. For optimum results, therefore, he recommended that complete neutralization be maintained throughout day and night. According to this concept, any method which accomplishes such twenty-four-hour-a-day neutralization is worthy of consideration.

How, then, might this goal be achieved? Extirpation of the entire secreting portion of the stomach, if safely and successfully performed, is undeniably one way in which elimination of secretion can be achieved. To many of us, such an "if thy hand offend thee" assault seems much too radical an approach to the problem of simple peptic ulcer.

Vagotomy has been proposed, tried, and by most observers found sorely wanting, as a reliable and uncomplicating means of eliminating gastric secretion. The experiment has, however, been of signal usefulness in reviving interest in the "no acid-no ulcer" dictum among surgeons as well as general practitioners and internists. Elaborate medical procedures such as the continuous antacid drip proposed by Winkelstein are equally sound, although to those who are experienced in the use of less complicated methods of accomplishing neutralization, they seem unduly burdensome to the patient.

It is true that the so-called "Sippy management" is likewise considered by many to be so difficult as to be impracticable. Unquestionably, the method is not easy, but it is by no means as ponderous as it seems to those who have observed it only during the initial stage of hospitalization. This phase has received so much attention in hospital procedure outlines, publications, and during internships, that it overshadows the much more liberal program which follows dismissal from the hospital. Nevertheless, the rigid early stage of treatment is essential, and cannot be modified without jeopardizing the result. For those of us engaged in metropolitan practice, hospitalization for one week is mandatory, due to our obvious inability to carry on close observation of the patient in his home. In a community practice, it would not be impossible to achieve the same result by home care.

Before entering into a discussion of the details of this method of ulcer management, one brief divergence from the subject of treatment must be made. Good treatment is inextricably dependent on accurate diagnosis, and the deplorable tendency to base the diagnosis of peptic ulcer on x-ray evidence alone must receive critical comment. So often, treatment is written off as a failure because the condition under treatment was *not* active peptic ulcer, and therefore should not have been expected to respond. Not infrequently, patients referred as "intractable" peptic ulcers are found to have no clinical evidence of activity, and sometimes no free hydrochloric acid even during distress. The absurdity of feeding alkalies to an achlorhydric patient requires no comment, and yet this practice of treating an x-ray shadow, rather than a clinically diagnosed disease, is astoundingly prevalent. It is recommended that no patient (except those with evidence of hemorrhage or threatened perforation) be subjected to ulcer treatment until aspiration of the stomach during typical distress has revealed free hydrochloric acid, and cold-water lavage has produced complete, immediate relief.

The immediate objective of treatment, as previously stated, is to bring about complete neutralization, day and night, of the free hydrochloric acid in the gastric contents. To this purpose, advantage is taken of a buffering substance such as milk, alternated with a suitable chemical neutralizer. Since either of these will have left the stomach, and/or lost its effectiveness, after thirty minutes, the usual schedule must be essentially as follows:

Milk (or milk-cream mixture if full nutrition is needed): three ounces every hour from 7 a.m. to 7 p.m.

Neutralizing agent, such as calcium carbonate or tribasic calcium phosphate, every hour on the half-hour from 7:30 a.m. to 7:30 p.m., and (to complete neutralization of the secretory response to the evening nourishment) every half-hour from 7:30 p.m. to 9 p.m. Later night powders will be required if a continued night secretion is demonstrated. The dosage of the neutralizing powder is based on the concentration of hydrochloric acid found in the aspiration during distress, and in the subsequent aspirations during treatment.

During the initial week of hospitalization, additional feedings are introduced somewhat as follows:

First day: No additional feedings.
Second day: One additional feeding.
Third day: Two additional feedings.
Fourth day: Three additional feedings.
Fifth day: Four additional feedings.
Sixth day: Five additional feedings.
Seventh day: Six additional feedings.

These feedings may be the patients' own selection from a list which includes: farina, poached egg, custard, jello, egg-nog, cream soup, tapioca, and ice cream. It will be noted that, at the end of this first week, six daily feedings will be taken (usually at 8, 10, 12, 2, 4 and 6 o'clock). This is sufficient nourishment to sustain moderate activity, permitting a return to ordinary occupation at the end of the week of hospitalization.

Good management requires that many objectives other than the mere establishment of this schedule must be accomplished during the all-important first week. It is vital that the patient receive a thoroughgoing explanation of his ailment, the reasons for each step in his treatment, and the outlook for immediate and permanent recovery. Ulcer patients are usually intelligent and analytical, and respond excellently to a sincere, truthful discussion of their problems. Resistance to the tedious program readily melts away before a sympathetic, confident explanation of what is necessary, and why.

Part of this indoctrination program is to explain the need for check-up aspirations of the stomach, and to convince the apprehensive patient that he can easily learn to do these for himself. During the week of hospitalization, one aspiration is done each night, using the Ewald-type tube. Nine-thirty p.m., midnight, and 3 a.m. are the times at which experience has shown unneutralized free hydrochloric acid most likely to be present. Therefore, a rotation of aspiration at these hours is followed, to the end that six night aspirations may be accomplished during the first week. Additionally, one 4 p.m. aspiration is desirable as a check on the usually adequate daytime neutralization.

This introduces the subject of continued secretion, usually considered a complication of peptic ulcer. However, in the experience of the writer, it is the rule rather than the exception. Of all ulcer patients treated by me, in private practice, during the past five years, 76 per cent were proved to have a continued secretion requiring that neutralizing powders be continued beyond the limits of the schedule previously outlined.

This, then, would indicate that continued secretion (or night secretion) properly belongs in a discussion of the management of simple peptic ulcer, since a manifestation present in the majority of patients can hardly be considered a complication, in the true sense. Failure to discover, and deal with, such a secretion, is probably the most important obstacle to success in this form of treatment. It must be remembered that the acid-pepsin threshold for corrosive interference with healing is usually lower than the threshold for ulcer pain production from this source. Hence the patient who is perfectly comfortable on "routine" ulcer management may have an un-neutralized night secretion which is busily undermining all the gains of an ever-so-careful daytime program.

Once a night secretion is detected, the counter-measures are obvious. If free hydrochloric acid is present at 9:30 p.m., a "night powder" (usually twice the amount of the regular daytime powder) is given. Thus, if the dose of the regular powder

has been established, for example, as 60 grains of tribasic calcium phosphate, the "night powder" would be 120 grains of the same. During the lessened gastric activity of sleep, this can be expected to remain in the stomach and exert a neutralizing effect for several hours. If free acid is present at midnight, the night powder is likewise given at that hour, and also at 3 a.m. if acidity can be demonstrated at that hour. This adjunctive treatment is continued until subsequent check-up aspirations show that there has been a cessation of night secretion. With accurate management, night powders are seldom necessary for longer than a few weeks.

During the week in the hospital the patient has also had the advantage of rest, which is unquestionably of great importance in the initiation of healing. He will have learned to offset the usual constipating effect of the powders by the substitution of a sufficient number of laxative neutralizing powders (usually three doses of magnesium oxide, grains 15). He will have acquired the art of self-aspiration and the ability to test for the presence or absence of free hydrochloric acid. In short, he will have learned an individualized program directed toward complete neutralization, and will be capable of carrying it out on his own, after dismissal from the hospital.

The six-feeding schedule of the last hospital day is continued after dismissal, for two weeks more. The patient then reports, bringing a stool specimen for the benzidine test. His symptoms, if any, and the results of his aspirations, are reviewed, and he is examined for objective findings. If all is well, he is given instructions for the next (fourth) week of his program.

Fourth week management involves a welcome change to three small meals per day, and discontinuance of the 7 a.m. milk and 7:30 a.m. powder. A powder is substituted for the milk which was previously taken one hour after the 8 a.m., the noon, and the 6 p.m. feedings. Ten ounces of solid food are allowed for breakfast and lunch, and eight ounces for supper. The food is selected from a menu which includes, of course, all of the previous "feedings," and in addition pureed fruits and vegetables, American, cream or cottage cheese, macaroni, rice, white bread, many frozen desserts, and sponge or angelfood cake.

After completing the fourth week, the patient again reports his progress and is re-examined, and the stool checked. If this trial on three small meals daily has been well tolerated and control of acid secreation has been maintained, he is ready for the final advancement in diet.

Management after the fourth week brings no change in the milk and powder schedule. Food allowances are increased to fifteen ounces of solids for morning and noon meals, and to ten ounces for supper. The menu is extended to include lean meat, fish, fowl, and raw fruits (with skins removed). Nothing need be pureed or chopped except coarse or leafy vegetables. Another office re-evaluation of progress is carried out after these changes have been in effect for a week, and if this is satisfactory, temporary interruption of powders will be tried.

An intermission of five consecutive days, after each five-week period of management, was found to be necessary in the days when a highly absorbable alkali such as sodium bicarbonate was used in the powder formulae. This permitted restoration of a normal acid-base balance, and prevented the ill-feeling which sometimes accompanied continuous use of highly ironized alkalies. With a powder of minimum absorbability such as tribasic calcium phosphate, it is true that no interruption would be necessary. However, the five-day interval is a pleasant relief from the routine, and past experience showed that these interruptions did not have an unfavorable effect on the end result. Moreover, these rest periods serve to verify the completeness of healing of the ulcer, as the sudden change from an inert to a normally active digestive juice should promptly cause the reappearance of ulcer-type distress. If such distress should develop, it would be the signal for immediate resumption of powders. Except for the stopping of powders and the temporary discontinuance

of aspirations, the schedule is not altered during this five-day interlude.

The patient reports at the office following this first five-day respite from powders. Usually, there will have been no distress, no abdominal tenderness will be found, and the stool will be negative to benzidine. It can then be presumed that the ulcer has healed and the first objective of treatment accomplished.

At this time it is well to discuss with the patient his future management. It can be pointed out that discontinuance of accurate treatment as soon as healing is obtained will be followed at some later date by recurrence, in most instances. Past experience can be cited to show that continuation of treatment to a total period of one year results in permanent cures in the great majority of cases. By this time most patients have learned to carry on the treatment without great difficulty, have become interested in the project as collaborators rather than victims, and almost invariably elect to go through the full year. In fact, most of them need to be urged to be somewhat less rigid in the routine.

This accurate ulcer management is continued to a total period of one year, interrupted by five-day intermissions from powders every five weeks. During this time the patient reports every three weeks, or, if he lives at a considerable distance, every six weeks. This careful follow-up is a powerful factor in the achievement of a good end-result. Fluctuations in gastric secretion which may require changes in powder dosage are dealt with. Thoughtful consideration is given to the influence that work, recreation, business or family problems, and the mental outlook in general, may be having on progress. Much of the tedium is eliminated by taking the patient through the year visit by visit, with encouragement and reassurance which can offset any tendency to drift away from the regime.

At the end of the year, treatment is entirely discontinued except for avoidance of the exceptionally irritating foods and drinks which would be interdicted by ordinary common sense. Statistical studies in the past have indicated that the highest percentage of permanent cures resulted from management maintained for one year. Shortening this period, even slightly, caused a great increase in the frequency of subsequent recurrence, whereas extending it to as long a time as two years brought no improvement over the one-year results. It seems to follow that accurate management for one year provides the optimum time for restoration of the unknown factor or factors opposing recurrent ulceration. This concept is thoroughly explained to the patient. Although the probability of a lasting good result is emphasized, he is never permitted the belief that he is assured against the possibility of recurrence.

Problems which arise in conducting this form of treatment, once it is launched, are surprisingly few. With tribasic calcium phosphate as the neutralizer, alkalosis never develops. Sometimes, during the first week of treatment, a patient will experience a psychological revulsion against the regime. This may be overcome by immediate temporary interruption of the powders, or by replacement of the milk and cream mixture by plain milk. If milk intolerance, or a milk allergy, exists, gelatin or protein hydrolysate can be substituted as a combining agent. Constipation or diarrhea can quickly be overcome by regulation of the magnesia dosage. Unusually persistent night secretions may require that the patient empty his stomach by tube at bedtime, during a succession of nights. Severe complications such as hemorrhage, perforation, or obstruction, simply do not occur in patients who are steadfastly maintained on accurate neutralization.

Of the innumerable antacids available for use in ulcer treatment, calcium carbonate and tribasic calcium phosphate are, in the experience of the writer, by far the most effective and most suitable. Calcium carbonate is the more efficient, but tribasic calcium phosphate is less absorbable and therefore somewhat safer to use. Both are inexpensive, an important consideration in view of the quantity used. Contrary to theories advanced by some, no increased incidence of urinary calculi, following free

use of these substances, has been established. Aluminum hydroxide preparations are safe but inefficient. Mucin is disagreeable to take and has little neutralizing value. Anion exchange resins are expensive and ineffectual alternatives.

Inhibitory drugs such as atropine and the newer anticholinergic drugs are advocated as a means of lessening gastric secretion and spasm. To those of us who insist on complete neutralization, this has little application, because secretion is promptly nullified and secondary spasm eliminated by the method of treatment just described. The writer's experience to date in attempting to lessen continued secretion by the adjunctive use of anticholinergic drugs has been disappointing. Detergents and antihistamines have no demonstrable practical value in man.

Hormones, such as enterogastrone, received eager interest for their possible application to ulcer treatment, a few years ago, but no true or lasting value has been demonstrated.

Roentgen irradiation of the stomach, for inhibition of gastric secretion, is among the interesting experimental approaches now under investigation.

Sedatives are seldom needed by the supposedly "nervous" ulcer patient, once his nagging distress has been eliminated by the neutralization program.

Summary

Effective medical management of peptic ulcer is hampered by the readiness with which symptoms may be eliminated by faulty treatment, by the lack of a known specific cause to treat, by the confusing plethora of alleged "cures," by the fallacious doctrines that peptic ulcer is either incurable or altogether psychogenic, and by such insistence on newly discovered forms of treatment that established methods of value are rejected.

The fundamental concept of treatment by complete neutralization, introduced by B. W. Sippy forty years ago, still offers the greatest probability of immediate and permanent success. Other methods of achieving complete neutralization are either objectionably radical or unduly troublesome.

Details of the method of attaining complete, twenty-four-a-day neutralization, by the alternation of milk and a neutralizing agent such as tribasic calcium phosphate, have been outlined. The frequency of continued night secretion, and methods of control, have been emphasized.

At present, no other method of medical management offers comparable results.

AUXILIARIES TO HELP AMEF

A new method of recording AMEF contributions has been accepted by the Woman's Auxilary to the American Medical Association. Auxiliary donations will be sent to the authorized Auxiliary State Representative and forwarded to Mrs. Frank Gastineau, national AMEF Auxiliary Chairman, at Indianapolis, Indiana, at the end of April, 1955. In addition to Mrs. Gastineau's recent directive to AMEF Auxiliary Chairmen, a new pamphlet is being processed and should be available to her committee before the November meeting.

Mrs. Gastineau also announces the appointment of three new regional chairmen: Mrs. Oswald R. Carlander, Audubon, New Jersey, Eastern region; Mrs. J. L. Jinkins, Galveston, Texas, Southern region, and Mrs. Francis M. Fargher, Michigan City, Indiana, North-Central region. Mrs. Raleigh W. Burlingame of San Diego will continue as the Western Regional Chairman.

NEW FALL "MARCH OF MEDICINE" SERIES

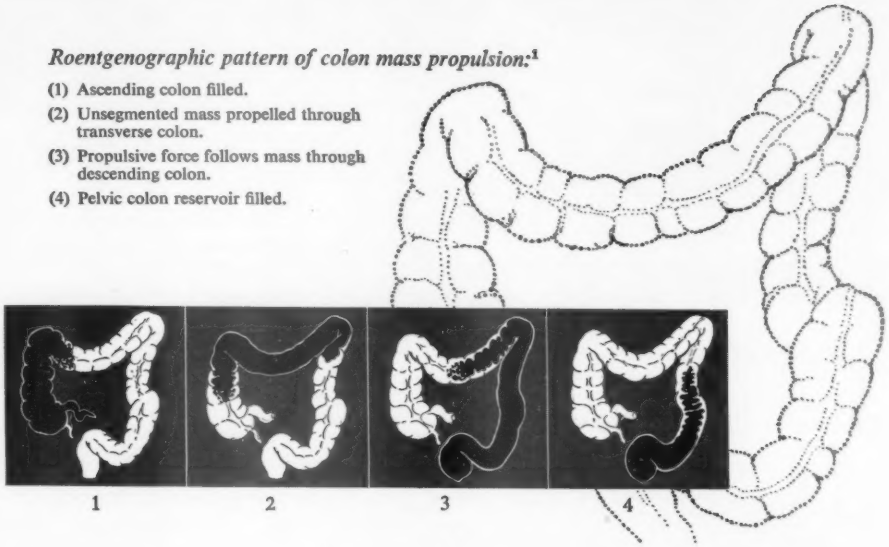
"The March of Medicine" national television program once again will resume its precedent-breaking telecasts with a program October 31 on mental illness. Presented by the American Medical Association and Smith, Kline and French Laboratories, "The March of Medicine" will be carried Sunday, October 31, at 5:30 p.m., EST, over some sixty stations of the NBC-TV network.

Focusing attention upon the difficult subject of mental illness, the program will stress research and treatment advances in the growing problem of schizophrenia. Outstanding authorities in this field of medicine will be featured as well as actual work under way in research laboratories and clinics throughout the country.

The final program in this fall series will be a special report in December during the AMA's Clinical Session in Miami. Another full series will be presented in the spring of 1955.

Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.
(2) Unsegmented mass propelled through transverse colon.
(3) Propulsive force follows mass through descending colon.
(4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.[2]

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Factors Contributing to Chronic Constipation

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

Dosage Considerations

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

The Washington Scene

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

When the Eighty-fourth Congress convenes in January, the Eisenhower Administration will press for passage of at least two bills that failed to get through last session, reinsurance and a new program of medical care for military dependents. The former was decisively defeated in the House. The latter did not reach a vote in either chamber.

In a radio address summing up his Administration's legislative achievements, Mr. Eisenhower confirmed that he was prepared to renew the fight next session to have the Federal Government set up a system for reinsuring health insurance programs. He declared: "Health reinsurance we are going to put before Congress again because we must have a means open to every American family so that they can insure themselves cheaply against the possibility of catastrophe in the medical line."

There have been no indications how far the Administration would go in amending the reinsurance bill to satisfy its critics. It is possible also that if all objectionable features were removed there would be little left of the bill.

At Senate and House hearings, reinsurance was roundly denounced by most witnesses, for a variety of reasons. A.M.A.'s position was that reinsurance wasn't needed because private funds are available for the limited amount of reinsurance that could be used, and that in addition the program projected the Federal Government too far in the direction of control of medical care.

Later in the session, Mr. Eisenhower himself and Mrs. Hobby made every effort to win over critics of reinsurance, and to force the bill through Congress. In the light of these efforts —including a nationwide radio appeal by Mrs. Hobby—the defeat of the bill in the House of Representatives was regarded as one of the most surprising suffered by the Administration on any domestic legislation.

Currently Secretary Hobby and Chairman Charles Wolverton of the House Interstate and Foreign Commerce Committee are attempting to bring together all parties interested in health legislation to see if a compromise can be worked out on reinsurance.

Although the dependent medical care bill wasn't passed, this fact was not in any way regarded as a defeat for Mr. Eisenhower. The bill was offered in the Senate in plenty of time for action, but the introduction of the House bill was held up until Defense Department could estimate the first year's cost, eventually set at $67 million. At any rate, neither Senate nor House Armed Service Committee held hearings on the measure.

In another statement, Mr. Eisenhower made it clear that he expects the next Congress to do something about improving and making more uniform the system of medical care for servicemen's families. Congress, he said, "must eventually meet certain imperative needs of the members of the armed forces." He explained that servicemen now "lack adequate medical care for dependents. . . . It is most important that these needs of the armed forces personnel serving their country often in remote corners of the world engage our serious consideration."

Although the American Medical Association has not had an opportunity to testify on the dependent care plan before Congressional committees, it has made its views known to the Defense Department. In general the A.M.A. is not opposed to Defense Department proposals that a more uniform system be worked out, and that the Federal Government bear most of the cost. On one important point, however, the recommendations of the department and of the Association are in direct conflict: The department would have the military medical departments themselves furnish dependent medical care wherever they could, with service families going to private physicians and private hospitals only where the uniformed physicians couldn't handle them. The Association, on the other hand, proposes that dependents be cared for by the military medical departments only where civilian medical facilities are inadequate to furnish proper care.

Federal officials, meanwhile, are busy preparing to put into effect the new health bills passed by Congress. Basic state allotment percentages have been worked out for the new Hill-Burton program (for facilities other than complete hospitals) and for the expanded vocational rehabilitation program. The Internal Revenue Bureau is about to issue detailed instructions to taxpayers regarding changes in medical expense deductions and other benefits in the new tax law.

FOR FREE ENTERPRISE AND FREEDOM OF CHOICE . . .

Colorado Medical Service and Colorado Hospital Service offer sincere congratulations on the outstanding success that you, the doctors and hospitals of Colorado, have made of the Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield, under your sponsorship and guidance, now serve nearly half of all the residents of Colorado. These two plans have done a great deal to maintain the principles of free enterprise in the Colorado hospital system and to maintain the freedom of the people of Colorado to choose which doctor shall serve them.

In addition, under the guidance of Colorado doctors and hospital administrators, Colorado medical and hospital practices have established a proud record of achievement.

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DIGEST OF MINUTES

SPECIAL SESSION
NEW MEXICO HOUSE OF DELEGATES

August 28, 1954, Santa Fe

At the May meeting of the House of Delegates of the New Mexico Medical Society, there was created a special committee to investigate the health insurance problems of New Mexico. This committee was directed to hear the interested parties and to report back to the House of Delegates during August of 1954, with its recommendations as to which, if any, health insurance plans in New Mexico should be given the approval of the State Medical Society.

President John F. Conway, with the advice and consent of the Nominating Committee of the State Society, appointed the following committee to investigate the health insurance problems:

R. V. Seligman, M.D., chairman, Albuquerque.
Wendell Peacock, M.D., Farmington.
Frederic E. Cressman, M.D., Artesia.
A. D. Maddox, M.D., Las Cruces.
Frank W. Parker, M.D., Gallup.

The committee employed the services of Mr. William Sloan as legal counsel, and Mr. Clay Pooler as insurance counsel.

The Special Session of the House of Delegates, which was called specifically to receive the report of the Investigating Committee, met in the La Fonda Hotel, Santa Fe, on August 28.

The committee made nine recommendations to the House of Delegates. All of the committee's recommendations were approved by the House, with the additional recommendation which was made from the floor of the House, that

> "The New Mexico Medical Society wholeheartedly support New Mexico Physicians' Service, and encourage all of the members of the Society to become professional members of New Mexico Physicians' Service and that everyone take an active part in encouraging the doctor's patients to participate in the plan."

The committee's recommendations to the House were:

1. That the Society should regard the approval or disapproval of medical and surgical insurance plans as a matter of grave concern, and should give thorough investigation and consideration to requests for such approval.

2. That the request of Surgical Service, Inc., as it now exists, for approval by New Mexico Medical Society, be denied.

3. That New Mexico Physicians' Service be approved by the Society, and that the present and former members of the Board of Trustees thereof are to be commended for their service to the Society and to the public in the conduct of the affairs of the New Mexico Physicians' Service since its foundation in 1946.

4. That the members of the Board of New Mexico Physicians' Service be appointed as a permanent insurance committee of the New Mexico Medical Society for the purposes of:

(a) Serving in a supervisory capacity of all approved plans by the New Mexico Medical Society.

(b) Recommending the approval or non-approval by the New Mexico Medical Society of medical and hospital insurance plans.

(c) To accept and approve new private carriers of insurance to sell the New Mexico Physicians' Service Plan of the New Mexico Medical Society.

This recommendation was adopted by all the committee except the chairman, who abstained from voting.

5. That the New Mexico Medical Society should continue to encourage private carriers to participate in the New Mexico Physicians' Service Plan.

6. That a special committee be appointed for the specific purpose of further exploring the possibility of an agreement or working agreement between the Hospital Service Plan of the Blue Cross and the Surgical Plan of the New Mexico Physicians' Service.

7. That the New Mexico Physicians' Service be directed to review the form of policy written by its private insurance carriers, to ascertain whether or not it is possible to provide in the policies for reimbursement of extras on the basis of some multiple of the daily benefit, rather than by a fixed indemnity as is provided in the present policy forms.

8. That the New Mexico Medical Society go on record as opposing any and all encroachments upon the traditional conduct of the practice of medicine by private medical practitioners.

The House of Delegates, while in session, accepted an invitation from the Chaves County Medical Society to hold the 1956 Annual Meeting of the State Society in Roswell.

Official Visitation

Since 1949, the President, Executive Secretary and other officers of the New Mexico Medical Society have tried to visit all of the organized

A new long-acting narcotic —

Levo-Dromoran Tartrate 'Roche'...
a new form of synthetic narcotic...
usually longer acting than
morphine...less likely to produce
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in very small doses (2 to 3 mg)...
given orally or subcutaneously...
Levo-Dromoran® -- brand of levorphan.

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Nisentil 'Roche' usually relieves pain within five minutes after subcutaneous injection...lasts for an average of two hours... especially useful for painful office and clinic procedures...Nisentil® Hydrochloride -- brand of alphaprodine hydrochloride.

County Medical Societies during the year that the President is in office. In addition to the formal visits of the officers to the County Medical Societies, the Executive Secretary annually visits the members-at-large. Members-at-large are those members who practice in areas in which there is no County Medical Society.

This year Dr. John F. Conway, President, New Mexico Medical Society, arranged an itinerary for visiting County Medical Societies, beginning September 8 and ending October 9. The officers will have visited two County Medical Society meetings per day during a three-week period.

OFFICERS OF COMPONENT SOCIETIES NEW MEXICO MEDICAL SOCIETY 1954

Bernalillo County
President: T. E. Kircher, Jr., M.D.
Vice President: L. A. McRae, M.D.
Vice President: Robert Friedenberg, M.D.
Secretary-Treasurer: John H. Dettweiler, M.D.

Catron-Socorro-Torrance-Valencia County
President: W. F. Wittwer, M.D.
Vice President: V. E. Franklin, M.D.
Secretary-Treasurer: M. Zenos Smith, M.D.

Chaves County
President: Frank A. English, M.D.
Vice President: L. M. Kinman, M.D.
Secretary-Treasurer: D. H. Cahoon, M.D.

Colfax County
President: V. K. Adams, M.D.
Vice President: J. S. Gunter, M.D.
Secretary-Treasurer: R. L. Fuller, M.D.

Curry-Roosevelt County
President: V. Scott Johnson, M.D.
Vice President: Joel Ziegler, M.D.
Secretary-Treasurer: Edward Craffey, M.D.

Dona Ana County
President: Andres M. Babey, M.D.
Vice President: J. C. Sedgwick, M.D.
Secretary-Treasurer: L. L. Daviet, M.D.

Eddy County
President: Frederic E. Cressman, M.D.
Vice President: G. C. Hogsett, M.D.
Secretary-Treasurer: Owen C. Taylor, M.D.

Grant County
President: Sidney F. Baker, M.D.
Vice President: R. C. Wille, M.D.
Secretary-Treasurer: C. C. Cobb, M.D.

Lea County
President: W. E. Badger, M.D.
Vice President: H. W. Hodde, M.D.
Secretary-Treasurer: A. V. W. McBee, M.D.

Los Alamos County
President: Paul H. Noth, M.D.
Vice President: David B. Post, M.D.
Secretary-Treasurer: J. O. Logan, M.D.

Luna County
President: L. J. Whitaker, M.D.
Vice President: Paul A. Feil, M.D.
Secretary-Treasurer: W. J. Hossley, M.D.

McKinley County
President: Vincent Accardi. M.D.
Vice President: John W. Martin, M.D.
Secretary-Treasurer: Louis H. Bos, M.D.

Quay County
Not reported.

San Juan County
President: L. B. McCarty, M.D.
Vice President: O. B. Fischer, M.D.
Secretary-Treasurer: W. B. Marbury, Jr., M.D.

San Miguel County
President: Henry C. Hosford, M.D.
Vice President: Charles L. Blanchard, M.D.
Secretary-Treasurer: Volney S. Cheney, M.D.

Santa Fe County
President: Howard M. Seitz, M.D.
Vice President: Earl Pace, M.D.
Treasurer: Warner Crouch, M.D.
Secretary: Margery U. Whipple, M.D.

Sierra County
President: E. E. Hubble, M.D.
Vice President: H. B. Johnson, M.D.
Secretary-Treasurer: T. B. Williams, M.D.

Taos County
President: Reynaldo Deveaux, M.D.
Secretary-Treasurer: Martha E. Howe, M.D.

Obituary

WALTER I. WERNER

Walter I. Werner, Albuquerque, was killed in a plane crash in Iowa on August 22, 1954. He was 56 years of age.

Dr. Werner was graduated from the University of Maryland in 1923. He had practiced in Albuquerque since 1935.

He was a specialist in internal medicine and allergies and was a governor of the American College of Physicians. He was a member of the Bernalillo County Medical Society, New Mexico Medical Society, American Medical Association, American Trudeau Society, and American College of Allergists.

Dr. Werner is survived by his wife, Ly Werner, M.D., and a son, Walter G. Werner, who is an Ensign serving with the U. S. Navy in Indo-China.

ELECTIONS

Your State's Executive Office appreciates being notified of the results of your component society elections. Not only can State Secretaries thus keep their records up to date, but they are better able to route inquiries to the appropriate component society officer.

Highlights of the 84th Annual Session

"One of the best"—was the comment heard all around the Broadmoor Hotel in Colorado Springs September 24 and 25 as members by the hundreds were commenting on the Eighty-fourth Annual Session of the Colorado State Medical Society while packing up and checking out to return to their homes and practices. In attendance it was the largest state meeting ever held outside of Denver. Total registration was 981 which included 610 physicians. Non-physicians registered included wives and families of the doctors, exhibitors, members of allied professions, and a few lay visitors.

Spirited discussions in the four meetings of the House of Delegates evidenced more than the usual deep interest in the work of this policy-making body. There were even some contests, though friendly contests, in the matter of nominations for high office in the Society.

The New President

Dr. Robert T. Porter of Greeley was elected President-elect of the Society, and will succeed to the Presidency next September 23 at the close of the Eighty-fifth Annual Session to be held in Denver. Dr. Samuel P. Newman of Denver assumed the Presidency at this last Annual Session upon the retirement of President Claude D. Bonham.

For the few who do not know him well, here are a few biographical notes about Dr. Porter. Born in Rockford, Illinois, July 25, 1904, he attended local public and high schools and then the University of Chicago, where he earned his B.S. degree and went on to the M.D. degree at the University of Chicago's School of Medicine. He attained the M.D. in 1931, interned at Michael Reese Hospital for a year and then had a three-year residency in internal medicine at Billings Hospital. He moved to Greeley, Colorado, in 1935, immediately joined the Weld County Medical Society, and has been active in his chosen specialty and in the affairs of medical organizations ever since. He is now a member of the Greeley Clinic, heading its department of internal medicine.

ROBERT T. PORTER, M.D.

Dr. Porter is a veteran of World War II, having served first as a Captain and later as Major with the Thirty-first General Hospital in the South Pacific and in the Philippine Islands. In recent years he has served as Chief of Staff of the Weld County General Hospital, has held many offices in the Weld County Medical Society, and has just concluded a three-year term as a member of the Board of Trustees of the Colorado State Medical Society. He was chairman of that Board's Finance Committee during the year just closed. He is a Fellow of the American College of Physicians and is a Diplomate of the American Board of Internal Medicine. He and Mrs. Porter have two children.

House to Meet Twice a Year

Several important departures from traditional operations were directed by the House of Delegates last month. Among the most important is that hereafter the House will meet twice a year, convening during the week of the Annual Midwinter Postgraduate Clinics as well as during the Society's Annual Session. This, the House felt, would relieve Delegates of at least part of the crush of business at Annual Sessions which prevents Delegates from taking part in the scientific meetings, and at the same time it will further the democratic idea of having the House itself pass frequently upon major policies of the Society. The next meeting of the House, therefore, will be in mid-February of 1955.

Other important actions of the House included these:

It directed the Board of Trustees to organize an orientation course for new members of the Society on medical ethics, the nature of local, state, and national medical organizations, and the obligations of membership in them. Attendance at such courses will be mandatory.

It also directed that a special orientation meeting be held annually for all new officers and committee chairmen of the Society, immediately following the Annual Session.

It adopted the major recommendations of an Organization Study Committee (including the idea of two House meetings a year) designed to clarify the authority of all officers, make Society operations more efficient, and develop better continuity in Society activities from one administration to the next. One of the changes inaugurated through this report contemplates overlapping terms of at least two years for all committees so that only one-half the membership of any committee goes out of office with any change of administration. Also, the Nominating Committee, formerly consisting of seven Delegates, will consist of nine Delegates, one from each Councilor District, and it will be elected at the February meeting. It is then to publish its proposed ticket in the August

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USE FILMTAB ERYTHROCIN STEARATE against the cocci . . . and especially when the organism is resistant to other antibiotics. Low in toxicity—*it's less likely to alter normal intestinal flora than most oral antibiotics.* Conveniently sized (100, 200 mg.) in bottles of 25 and 100. Abbott

*TM for Abbott's film sealed tablets, pat. applied for

House of Delegates' Handbook. Delegates may still make nominations from the floor of the House at the Annual Session, after having had more time than before to study the list of candidates. A final recommendation of the committee was to have three Past-Presidents study the Constitution and By-Laws and propose any needed amendments next year to implement the spirit of the general reorganization.

Membership Simplified

The By-Laws were amended to simplify membership classifications, which over the years had become highly complicated and difficult to understand. Hereafter the Society's Emeritus Members, while still being relieved of dues, will be able to retain active membership status in all ways except dues payments, including the right to vote and hold office. The total membership classifications were reduced from nine to six, and an amendment was proposed for action next year for a still further reduction to four. This will simplify the work of county society secretaries, and will avoid misunderstanding over types of membership that have even brought protests from the Records Department of the A.M.A.

New Building Postponed

The Board of Trustees, after a year's study, had proposed that the Society build its own home-office building on a plot in the Denver Presbyterian Hospital land, immediately adjoining the new Denver Medical Library, and to do so out of the State Society's current reserve funds without assessment or increased membership dues. After long discussion, the House postponed final decision until February, and instructed the Board to continue its studies in this regard.

U.M.W. Fund Criticized

A recent directive issued by the United Mine Workers Welfare Fund which would deny beneficiaries of that fund the free choice of family physician which had been agreed to between the Fund and the Society in 1949 was discussed at length in the House of Delegates, which finally adopted a resolution vigorously protesting the directive and ordering suspension of activities of the Society's Advisory Committee to the U.M.W. Welfare Fund until such time as the matter has been corrected.

Program Complimented

Compliments were many for the quality of the scientific program. Attendance at the scientific sessions was excellent, and in a few instances overflowed the Broadmoor Hotel's "Little Theater." This was especially true of the closed-circuit television symposium on Hypertension, telecast by the American College of Physicians

from New York City and heard and seen in twenty-three cities over the country. Its planning had coincided with this Society's Annual Session and it was therefore added to the regular program. Sound advice on physician-patient relationships and relationships even between physicians' wives and their husbands' patients was given with a dressing of humor by Dr. W. W. Bauer of A.M.A. Headquarters at the annual banquet, which drew an attendance of 319. Many of the papers delivered at the meetings will be published later in the Rocky Mountain Medical Journal.

Blue Shield Income Limits

On recommendation of the forty-eight-member Blue Shield Fee Schedule Advisory Committee, approved by a reference committee of Delegates, the House advised the Blue Shield Board of Trustees to raise the income limits of its Preferred Plan. Current income limits for full service-coverage have been $2,600 per year for individual subscribers and $4,500 for families. The recommended new limits are $3,500 for individuals and $6,000 for families on a full servce basis. The committees also recommended, and the House approved, making the Standard Blue Shield Plan (with individual limits of $1,600 and family limits of $2,400) available to Class A pensioners, to help remove the stigma of indigency from pensioners, and recommended that Blue Shield inaugurate a "catastrophic coverage" rider that holders of the Preferred Plan may purchase optionally.

Society Awards Certificates

Two of the Society's annual Certificates of Service were awarded this year by the House of Delegates for special public service, both on nomination of the Board of Trustees. One went to Mr. Rex G. Howell of Grand Junction, owner of Radio Station KFXJ, with a citation naming him a "Public Benefactor in Radio Education." The other was granted to Miss Jane Woodhouse, Assistant City Attorney of Denver, citing her as "Tireless Worker for Mental Health." Also through action of the Board of Trustees, a special certificate of appreciation was issued to Mr. Harvey T. Sethman, Executive Secretary of the Society, in recognition of his having completed twenty-five years in that position on June 1, 1954. The annual Presidential Medallion and President's Certificate of Service were awarded to Dr. Claude D. Bonham of Denver immediately upon his retirement from the Presidency September 24, the award being made by newly installed President Samuel P. Newman.

New Officers

Following are the results of House of Delegates elections of new officers. For complete lists of the Boards including hold-over officers, readers are referred to the lists published for this and the other Rocky Mountain states among the first advertising pages in the front of the Journal.

President-elect: Robert T. Porter, M.D., Greeley, succeeding Samuel P. Newman, M.D.

Vice President: Kenneth D. A. Allen, M.D., Denver, succeeding Lawrence D. Buchanan, M.D.

Constitutional Secretary, for three years: James M. Perkins, M.D., Denver, succeeding Irvin E. Hendryson, M.D.

Treasurer: William C. Service, M.D., Colorado Springs, filling a two-year vacancy caused by the resignation of Frank I. Nicks, M.D.

Trustee, for three years: Lawrence D. Buchanan, M.D., Wray, succeeding Robert T. Porter, M.D.

Councilors, for three-year terms: Paul C. Hildebrand, M.D., Brush, succeeding himself; John D. Gillaspie, M.D., Boulder, succeeding Ella A. Mead, M.D.; Osgoode S. Philpott, M.D., Denver, succeeding himself.

Board of Supervisors, for two-year terms: Robert S. Hoover, M.D., Salida; Harold E. Haymond, M.D., Greeley; J. Alan Shand, M.D., La Junta; Sam W. Downing, M.D., Denver; Lester L. Williams, M.D., Colorado Springs; George G. Balderston, M.D., Montrose.

Board of Supervisors: V. V. Anderson, M.D., Del Norte, filling a one-year vacancy caused by the resignation of Albert P. Ley, M.D.

Delegate to the A.M.A., for two years beginning January 1, 1955: Kenneth C. Sawyer, M.D., Denver, succeeding William H. Halley, M.D.

Alternate Delegate to the A.M.A., for two years beginning January 1, 1955: Irvin E. Hendryson, M.D., Denver, succeeding Kenneth C. Sawyer, M.D.

Foundation Advocate: Walter W. King, M.D., Denver; succeeding himself.

Speaker of the House of Delegates: John A. Weaver, Jr., M.D., Greeley, succeeding Eugene B. Ley, M.D.

Vice Speaker of the House of Delegates: William B. Condon, M.D., Denver, succeeding John A. Weaver, Jr., M.D.

Denver was chosen for the site of the Eighty-seventh Annual Session, previous action of the House of Delegates having designated Denver for the Eighty-fifth Annual Session and Estes Park for the Eighty-sixth Annual Session.

Obituaries

THOMAS ARNOLD TRIPLETT

Dr. Triplett died on September 3, 1954, at the Veterans Hospital in Denver following a long illness. He was born in Alexandria, Virginia, July, 31, 1875, and received his early education in Virginia, coming on to Denver as a youth.

Dr. Triplett graduated from Denver and Gross Medical College in 1905 and was then licensed to practice in both Colorado and in New Mexico. He was a Life Emeritus member of the Colorado State Medical Society at the time of his death.

Surviving are his widow, Lillian of 1440 Josephine; two daughters, a son and a brother.

EDWARD W. REID

Edward W. Reid, M.D., of Flagler, Colorado, passed away at the Flagler Colorado Hospital of "Osteogenic Sarcoma." Dr. Reid was born August 17, 1875, in Linneus, Missouri. He received his M.D. from Washington University School of Medicine, St. Louis, in 1901. As a former member of the Colorado State Medical Society, Dr. Reid had practiced in Colorado for many years prior to his death.

Medical School Notes

POSTGRADUATE COURSE IN MEDICAL TECHNOLOGY

March 16 through 19, 1955, are the dates for a postgraduate course in Medical Technology at the University of Colorado Medical Center, 4200 East Ninth Avenue, Denver. Registration fee for the entire course will be $12.50, while $6.00 will be charged for a single day's registration. Principal guest speakers will be Thomas Hale Ham, M.D., Western Reserve University School of Medicine, and Mervin H. Grossman, M.D., Director of Laboratories, St. Paul's Hospital, Dallas, Texas.

The University of Colorado Medical Center and the Colorado State Society of Medical Technology are sponsoring the postgraduate course. Further information and application blanks may be obtained by contacting the Office of Graduate and Postgraduate Medical Education, 4200 East Ninth Avenue, Denver 20, Colorado.

CHARGES AT PREMATURE CENTER

Because of certain misunderstandings regarding rates for care of premature infants at Colorado General Hospital's Premature Infant Center, officials of the hospital wish to remind physicians and referring agencies that all admissions are on a basis of ability to pay some part of the total cost of the required care. It is emphasized that no family will be expected to assume a financial responsibility that is excessive for them, but every family will be expected to pay something toward actual costs in line with hospital admission policies. While premature infants were formerly cared for at no cost to the parents, withdrawal of federal funds made available to develop the Premature Infant Center now makes it imperative that admissions be put on a part-pay basis. Established rates currently allowed by county welfare departments for patient care at Colorado General also apply in the case of premature infants.

Physicians desiring additional details about Colorado's Premature Infant Care Program are invited to write or telephone Mr. Robert L. Denholm, Director's Office, at the Colorado University Medical Center; or the Premature Infant Center Office.

CARDIAC CONFERENCE PLANNED

The Third Annual Western Cardiac Conference, sponsored by the Colorado Heart Association, Colorado State Department of Public Health, Fitzsimons Army Hospital, Denver Veterans Administration Hospital and the University of Colorado School of Medicine, will be held in Denver, November 8-13, 1954, and is expected to attract about 400 physicians.

This combined conference on "Clinical Electrocardiography and Recent Advances in Cardiovascular Diseases" will be an outstanding medical event for physicians in Western United States. The clinical sessions have been arranged to emphasize every important advancement in diagnosis and management in the field of cardiovascular diseases.

Seven distinguished authorities in cardiology and competent Colorado teachers have been selected to make this an unusually practical review. The following leading specialists will serve as the guest faculty: M. M. Best, M.D., Louisville, Kentucky; William H. Bunn, M.D., Youngstown, Ohio; George C. Griffith, M.D., Pasadena, California; Gordon Myers, M.D., Detroit, Michigan; Myron Prinzmetal, M.D., Beverly Hills, California; Henry Schroeder, M.D., St. Louis, Missouri, and Paul Dudley White, M.D., Boston, Massachusetts.

The three-day Clinical Electrocardiography course, November 8, 9 and 10, 1954, conducted by Colonel Edwin M. Goyette, MC, is being given this year at the Veterans Administration Hospital Auditorium for the convenience of Denver physicians. This comprehensive and practical review is not surpassed in any postgraduate course in this country. Dr. Gordon B. Myers, Professor of Medicine, Wayne University, Detroit, is a superb teacher and will lecture on "Differential Diagnosis of Myocardial Infarction."

The conference on November 11, 12 and 13 will be held at the Cosmopolitan Hotel where lectures, panel discussions and a clinical-pathological conference and scientific exhibits have been arranged.

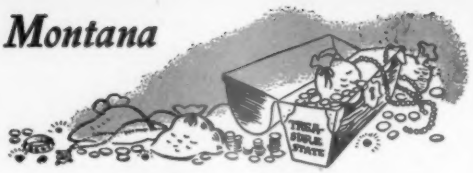
Information regarding the conference may be obtained from the Colorado Heart Association, 901 East Seventeenth Avenue, Denver, Colorado; telephone, AComa 2-7888.

SEVENTH PR CONFERENCE TO BE HELD IN MIAMI

Public relations tips "for doctors only" will be presented at AMA's seventh National Medical Public Relations Conference to be held in Miami Sunday, November 28, the day preceding the opening of the Clinical Session.

The program at the McAllister Hotel will be geared primarily for physicians, offering suggestions on ways to improve the medical profession's public relations at the grass roots level. Members of the House of Delegates, officers of state and county medical societies, executives and PR personnel are cordially invited.

Montana



HIGHLIGHTS
of
SEVENTY-SIXTH ANNUAL MEETING MONTANA MEDICAL ASSOCIATION

There were 217 physicians who attended the Seventy-sixth Annual Meeting of the Montana Medical Association, which was held in Butte, September 16 - 19. In addition, eighty - three members of the Woman's Auxiliary were present, fifty-seven technical exhibit representatives and thirteen members of affiliated groups.

The annual reception and banquet of the association was held Thursday evening, September 16, at the Finlen Hotel. Nearly 250 physicians and guests were present. The speaker at the annual banquet was Mr. Palmer Hoyt, Editor and Publisher of The Denver Post. Mr. Hoyt warned the profession that, "If socialized medicine ever comes to America, it will be because the medical profession has failed to provide a better service to the people than they think they can get from socialism." . . . "As members of the oldest, most vital, most close-knit and most influential of all the professions, doctors, themselves, have the answer to the challenge to their independent practice," Mr. Hoyt said.

A four-point program for the medical profession to combat a growing tolerance toward socialized medicine was suggested by Mr. Hoyt:

1. A sound public relations attitude and program locally, regionally and nationally.
2. A return to a sounder relationship between doctors and their patients, similar to that inspired by the general practitioner and "family doctor" of yesteryear.
3. Endorsement and cooperation with sound and honest prepaid insurance plans.
4. Work with hospitals and improve the public relations of those overworked institutions.

Mr. Hoyt criticized the hospitalization program of the Veterans Administration. In spite of studies, investigations and changes in policy, he said, the VA program "still causes suspicion that it is becoming a vast, tax-subsidized institutional give-away for the benefit of persons other than veterans with service-connected disabilities or sickness."

"The taxpayers should," Mr. Hoyt said, "and I believe are willing to provide free hospitalization and medical care for veterans with service-connected disabilities. The judgment as to whether a disability or illness is directly or indirectly a result of service should be a liberal

one, giving the veteran the benefit of the doubt. Beyond that point, I would not step a foot."

To go further, he said, might mean hospital care for all veterans, for all manner of sickness, then their families, and the establishment of a "special class of preferred citizen."

"I do not believe the veterans themselves want this sort of thing," Mr. Hoyt declared.

Sidney C. Pratt, M.D., Miles City, President of the Montana Medical Association, presented awards to two Montana physicians who completed fifty years in the active practice of medicine during 1954. These physicians, Burton K. Kilbourne, M.D., Hardin, and Roy E. Seitz, M.D., Bozeman, were awarded certificates in recognition of their unselfish devotion to their patients and to their loyalty to the medical profession.

At the scientific sessions of the association, which were held on Thursday and Friday, September 16 and 17, the following physicians presented interesting and educational lectures:

Brewster S. Miller, M.D., New York, Director of Professional Education of the American Cancer Society.

John H. Randall, M.D., Iowa City, Iowa, Professor and Head of the Department of Obstetrics and Gynecology at the State University of Iowa College of Medicine.

Carroll B. Larson, M.D., Iowa City, Professor and Chairman of the Department of Orthopedic Surgery at the State University of Iowa College of Medicine.

Rubin H. Flocks, M.D., Iowa City, Professor and Head of the Department of Urology at the State University of Iowa College of Medicine.

Willis M. Fowler, M.D., Iowa City, Professor and Head of the Department of Internal Medicine of the State University of Iowa College of Medicine.

Robert T. Tidrick, M.D., Iowa City, Professor and Head of the Department of Surgery of the State University of Iowa College of Medicine.

Charley J. Smyth, M.D., Denver, Colorado, Director of Graduate and Postgraduate Medical Education of the Department of Medicine of the University of Colorado School of Medicine.

At the annual meeting of the House of Delegates on Saturday, September 18, all standing and special committees of the association presented reports for the information and approval of the delegates.

The organization re-endorsed continuation of the Montana chest x-ray service; encouraged formation of a Montana Diabetes Association, and recommended appointment of a committee to study and recommend possible methods to the Montana Highway Patrol, within scope of the M.M.A. field, of determination of medical competency of motor vehicle drivers.

It also recommended approval of a Uniform Vehicle Code in Montana, and in another resolution advocated investigation of possibilities of Montana pathologists establishing standards for

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Only a long tradition of breeding and cross-breeding for beauty, size, and color can produce a flower aristocrat.

Only **audivox** in the hearing aid field can trace an ancestry that includes both Western Electric and Bell Telephone Laboratories. **audivox** lineage springs from the pioneer experiments of Dr. Alexander Graham Bell, which were furthered by the development of the hearing aid at Bell Telephone Laboratories, and in turn, brought to fruition by Western Electric and **audivox** engineers.

Distinctly an aristocrat in its field, **audivox**, successor to Western Electric Hearing Aid Division, brings the boon of better hearing, and its enrichment of living, to thousands. With the magical modern transistor, with scientific hearing measurement and scientific instrument-fitting, serviced by a nationwide network of professionally-skilled dealers, **audivox** moves forward today in a proud tradition.

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determination of blood alcohol as an aid for Highway Patrol officials in motor vehicle safety programs.

The delegates also adopted a resolution recommending nomination of Father Anthony Ravalli, S.J., as one of the two citizens of Montana whose statues are to be placed in the Hall of Fame in Washington, D. C. Father Ravalli was the first physician in Montana and rendered extraordinary service to the Indians and early white settlers of this state, serving without recompense or hope of compensation.

The association also adopted a report of the Mediation Committee which read in part as follows:

"The Mediation Committee again wishes to bring to the attention of the House of Delegates of the M.M.A. that, in the majority of complaints received, a prior discussion between patient and physician as to fees to be encountered in the surgical, medical or radiological procedure would have prevented the presentation of such complaints.

"The committee realizes that, in cases where complications and a typical course or poor results are most unlikely, the physician should not unnecessarily add to the concern of his patient by unnecessary discussion of such possibilities. However, when such potential complications are anticipated to occur with reasonable frequency, then that possibility should be discussed freely and frankly with the patient. As examples of such situations, the committee has encountered complaints of reactions of abdominal operations in which no pathology was found, alergic disorders, and so forth. From its experience to date, the committee has convinced itself that the best possible public relations for the profession lies in the hands of the individual physician and his relationship with each one of his patients."

The association also went on record as supporting Referendum No. 58 providing for funds for improvement at the Montana State Hospital at Warm Springs, and Referendum No. 57 providing for needed improvements at the Montana State Training School at Boulder where 550 patients are now crowded into a space for 380.

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Recent physiological and clinical research confirms its adjunctive value in the diet of many patients

THE WIDE recommendation of wine as a gentle and pleasant stimulus to appetite, digestion, and the full enjoyment of a meal, has a sound basis in the findings of controlled research.

Results of some recent studies* are the following:

Influence of Wine on Appetite—Two wineglassfuls of 20 per cent alcohol (the concentration in the usual appetizer or dessert wine) have been found to relieve prolonged gastric tension. Two or three ounces of dry table wine can markedly increase the olfactory acuity and the appetite in anorexia, and stimulate caloric intake.

The Buffer Action of Wine in Digestion—The effect of wine on free and total gastric acidity is slower and more prolonged than that of plain alcohol. Because of the buffering action of its phosphates, organic acids and tannins, wine induces a less violent but more sustained increase in gastric secretion and gastric motility.

Wine Stimulates the Flow of Pepsin—Ingestion of moderate amounts of wine, notably white table wine, has been found to increase appreciably not only the volume but the proteolytic power of gastric juice.

Wine in the Diet of Oldsters and Convalescents—There are sound, physiological reasons, therefore, why the generally lax and achlorhydric stomach of older people and convalescents reacts favorably to the mild, secretory stimulation of wine taken at mealtimes. And wine offers other valuable vasodilating, soothing, relaxing effects . . . a little Port or sherry wine at bedtime is a valuable aid to normal sleep, and may obviate the need for sedative medication.

Wine to Brighten the Monotonous Diet—In the dull and often unappealing dietary regimen of many patients, a glass of wine can frequently provide a touch of interest and "elegance"—a psychological boost of inestimable value.

The Fine Wines of California—Wines of outstanding quality are coming from California nowadays. Somewhere in the rich soils of the State, each grape variety finds its ideal setting and comes to perfect ripeness each year. Just as essential, modern scientific methods result in wines of controlled quality standards, true to type—and what is highly important from your patient's standpoint—moderate in price. Wine Advisory Board, San Francisco 3, California.

*Research information on wine is available upon request.

OFFICERS OF COMPONENT SOCIETIES MONTANA MEDICAL ASSOCIATION 1954

Following are the officers of the component societies of the Montana Medical Association for 1954. Upon receipt of names of new officers the State Executive Office will notify the Rocky Mountain Medical Journal so that the list may be kept accurate.

Cascade County
President: H. V. Gibson, M.D.
Secretary: Frank J. Friden, M.D.

Fergus County
President: John W. Schubert, M.D.
Secretary: Paul J. Gans, M.D.

Flathead County
President: C. E. Trush, M.D.
Secretary: Kenneth Bruns, M.D.

Gallatin County
President: Frank J. Pickett, M.D.
Secretary: William H. Sippel, M.D.

Hill County
President: J. J. Wier, M.D.
Secretary: J. H. O'Leary, M.D.

Lewis and Clark Medical Society
President: P. D. Pallister, M.D.
Secretary: John J. Mitschke, M.D.

Mount Powell Medical Society
President: D. R. Reed, M.D.
Secretary: S. L. Walker, M.D.

Northcentral Montana Medical Society
President: William E. Hadcock, M.D.
Secretary: Roger D. Mason, M.D.

Northeastern Montana Medical Society
President: J. H. Williams, M.D.
Secretary: Henry J. Borge, M.D.

Park-Sweetgrass Medical Society
President: George J. Moffitt, M.D.
Secretary: Lindsay M. Baskett, M.D.

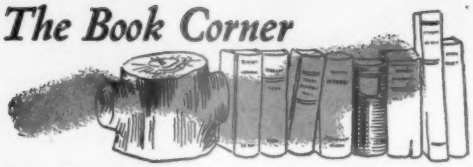
Silver Bow County
President: R. G. Kroeze, M.D.
Secretary: M. A. Gold, M.D.

Southeastern Montana Medical Society
President: R. O. Chambers, M.D.
Secretary: T. J. Malee, M.D.

Western Montana Medical Society
President: William F. Morrison, M.D.
Secretary: John F. Fulton, M.D.

Yellowstone Valley Medical Society
President: Robert Blomberg, M.D.
Secretary: Edwin C. Segard, M.D.

The Book Corner



New Books Received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Parents' Magazine Book for Expectant Mothers: By Adeline Bullock, R.N. Foreword by Jere B. Faison, M.D., Associate Attending Obstetrician and Gynecologist, St. Vincent's Hospital, New York City. Copyright, 1954, by Parents' Institute, Inc. Published by the McGraw-Hill Book Company, Inc. Price: $3.75.

The Physician and His Practice: By Eighteen Authorities. Edited by Joseph Garland, M.D., Editor of the New England Journal of Medicine. Copyright, 1954, by Little, Brown & Company, Boston 6. A source book of information regarding his career rather than as a detailed guide for the young doctor.

The Concept of Schizophrenia: By W. F. McAuley. Published 1954, by Philosophical Library, Inc., New York 16, N. Y. Price: $3.75.

The Encyclopedia of Child Care and Guidance: By Sidonie Matsner Gruenberg, Editor. Copyright, 1954, by Doubleday & Company, Inc. This is the most complete and authoritative guide to child care ever compiled. Conceived and written for parents, teachers, social workers, physicians, nurses, ministers, guidance counselors, and all whose lives are shared with children, it is a complete reference library in one easy-to-use volume. Price: $7.50.

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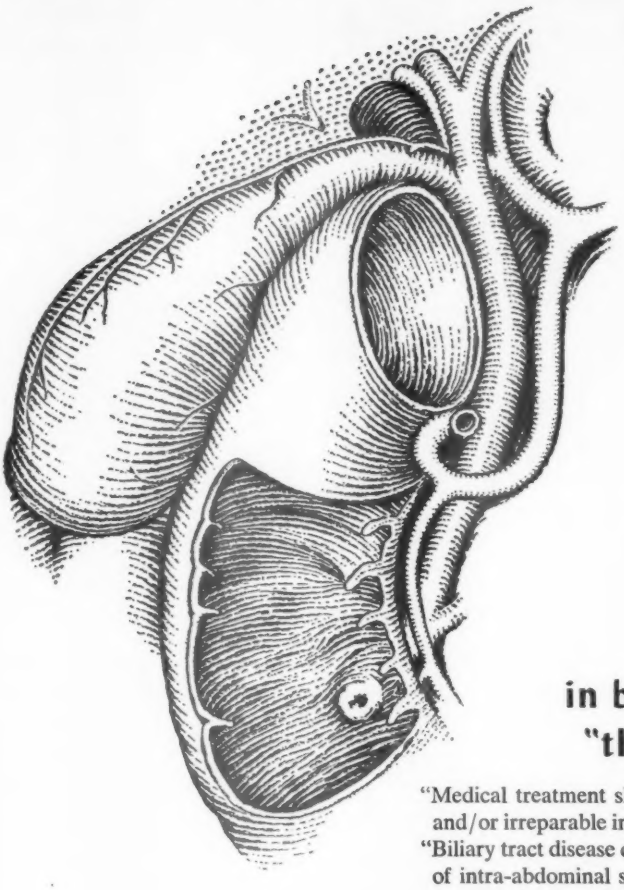

in biliary stasis... "therapeutic bile"

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"... increase the volume output of a bile of relatively high water content and low viscosity."[3]

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000. ***Decholin Sodium,*** 20% aqueous solution, ampuls of 3 cc., 5 cc. and 10 cc.; boxes of 3, 20 and 100.

1. Segal, H.: Postgrad. Med. *13*:81, 1953. 2. O'Brien, G. F., and Schweitzer, I. L.: M. Clin. North America *37*:155, 1953. 3. Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

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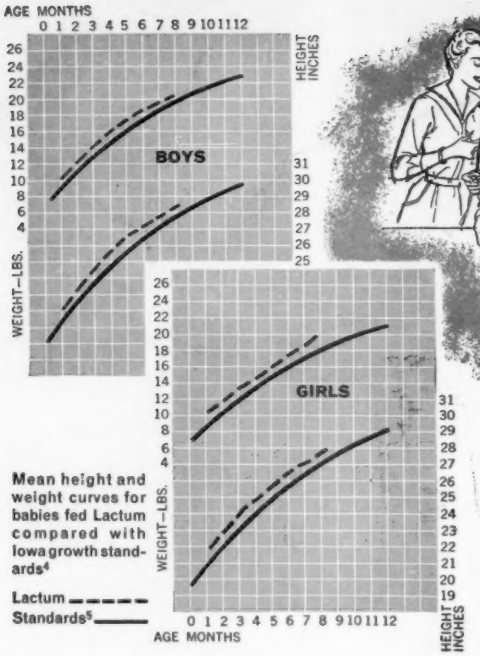

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The generous amounts of *natural milk protein* in Lactum contribute to an excellent level of satiety. Infants tend to have better dispositions and sleep well. Night feedings usually can be discontinued earlier.

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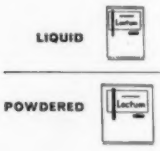
Lactum feedings are easy to prepare. One part of Liquid Lactum to 1 part of water, or 1 level measure of Powdered Lactum to 2 ounces of water, makes a formula supplying 20 calories per fluid ounce.

(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: Pediat. 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In Holt Pediatrics, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: J. Pediat. 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: J. Pediat. 27: 215, 1945.

Calculated on the basis of a daily allowance of 3.5 Gm. per Kg.



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